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FOR OCTOBER, 1917

THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment, and Administration of Hospitals, Sanatoriums, and Allied Institutions, and to their Medical, Surgical, and Nursing Services

Vol. IX *October, 1917* No. 4

FEDERAL INSPECTION AND CONTROL OF AMERICAN HOSPITALS*

Greater Efficiency the Demand of the War Epoch—Need for Compulsory Treatment of Syphilis and Infectious Diseases—Task of the American Hospital Association

By ROBERT J. WILSON, M. D., President of the American Hospital Association, New York

THE year that has passed since our last annual meeting is probably destined to be described as the beginning of the greatest epoch in the history of civilization. The foremost countries of the world are now waging a world war for equal rights for all the people. In order to prosecute this war effectively and vigorously, the various governments are attempting to conserve to the last degree every resource at their command, human and material, and to do this there is a general reorganization process going on that involves governments, states, communities, and even our very homes.

Business methods that stimulate production, that do away with waste, that prevent hoarding, that eliminate duplication, that bring the producer and consumer closer together, to their mutual advantage, are being created and adopted, and the improvements in government and the world of business made necessary by the exigencies of war will be to the lasting benefit of all the people.

Laggards in any walk of life cannot survive this reconstructive period, no matter whether they be individuals or societies. All must take stock of their methods and resources, and, if found to fall short of the standards established by the march of the times, must make such changes for the betterment of their condition as will insure their sure footing in the civilization of today.

This country has many national civic organizations whose whole aim is to benefit all the people; our own association is one of these and by its constitution and laws has assumed the responsibility of setting the high mark for efficiency and economy in everything that pertains to hospitals.

How well we have fulfilled our trust can best be judged by the service that the hospitals represented by our membership are giving the communities that support them. But service alone will not suffice to fill the public need; it must be the best service, and it should be a government-inspected, government-controlled, and frequently government-supported service. It seems to me that this association should use its best efforts to bring about a system or systems of federal, state, or municipal inspections that would insure to the public the minimum requirements necessary for the proper care and statistical records of the sick. The census bureau of the Department of Commerce attempts to record the statistical reports of the hospitals of this country. There is no law that I know of that compels hospitals to file such information, and the result is that the statistical records of the hospitals of this country on file in government records are of such a character as should make every one of us blush for their brevity and incompleteness. How can we improve this condition is the natural question. The answer should be easy. By demanding recognition for our proper place in the social economy of the country, by establishing minimum requirements for membership, which should be of such a standard as to insure at the very least good hospital care in a place properly administered and equipped.

I believe that the papers and reports to be presented at this conference and their discussion will help us in solving our various difficulties and give us enthusiasm to continue our work, which is the general purpose of our meeting.

*President's address, read before the American Hospital Association at its nineteenth annual session, Cleveland, September 11-14, 1917.

There are certain policies of administration, both of this association and of its units, that deserve your careful consideration. Hospitals, being public servants and taking into their wards the most helpless class of citizens, the sick and wounded, are under greatest obligation to the people for their existence, and, for their own protection and that of those they serve, should be under proper license and inspection, preferably governmental, but if not that, then through the restrictions of membership in this association. Every member of this association should resolve to furnish the United States Census Bureau with full and complete statistical information relative to the institution he represents, duplicate copies of which should be sent to the secretary.

This association should place itself on record as favoring laws for the compulsory treatment and control of infectious diseases, especially tuberculosis and syphilis, which by their insidious character do more harm than any of the others, and whose very insidiousness is often reflected in their mode of control by the authorities to whom they are entrusted. An effort should be made to have the diagnostic clinic of the hospital universally adopted. The admitting physician and his staff are naturally the most important officers in the hospital. The hospital patient should enter the ward and operating room with all the medical information obtainable, by recourse to every modern method of diagnosis, for the benefit of attending or operating physician.

At this time when each American is putting his shoulder to the wheel of national progress, when every heart longing for peace is willing to give up everything, even life itself, if peace can be honorably brought about and of lasting endurance, when every agency in our great country is readjusting itself to our national need, the American Hospital Association must by every means in its power help the government. We represent the hospitals of this country, and when they are called upon finally for that succor they must always give, let there be no chance to say they were called and found wanting, but rather that their zeal for service was well justified in their preparation for it.

HOSPITALS AND WORKMEN'S COMPENSATION*

Operation of Compensation Laws to Decrease Industrial Accidents and to Improve Traumatic Surgery—Problems Created for Hospitals—Fee Bills—Division of Fees Between Hospitals and Doctors

By THOMAS HOWELL, M. D., Superintendent, and KATHARINE BUCKLEY, Compensation Clerk, New York Hospital, New York

SINCE 1911 thirty-seven states and four territories have enacted workmen's compensation laws. There is probably no law which is today of more general interest and importance to hospitals.

New York, in 1910, was the first of our states to enact such a law, but in 1911 it was declared unconstitutional. Wisconsin and New Jersey placed workmen's compensation acts on their statute books in 1911, and these were upheld by the courts.

There is apparently no question as to the permanency of the workmen's compensation system in this country. A decision of the United States Supreme Court has upheld the rights of the states to enact such legislation. The three leading types of workmen's compensation insurance have been declared legal by this tribunal. These three types are exemplified by the Iowa law, under the provisions of which both employer and employee are at liberty to work under the statute or under common-law principles; the New York law, which is compulsory; and the Washington law, which is not only compulsory, but much broader in its provisions, including domestic and farm laborers, and requiring all employers to insure in the state fund, thus excluding private insurance companies.

The theory upon which these laws are based is this: A loss to the worker which is connected with and arising out of his employment shall, so far as possible, be charged to that industry in which he is employed as one of the costs of production and so distributed through the community. In other words, the cost of caring for accident cases is charged into the cost of production just as are capital, plant, labor, materials, fire insurance, and general overhead expenses, and thus become a proper and consistent charge upon society in general.

To illustrate how the law operates: The New York Hospital is located in a district in which there are numerous clothing factories. Previous to the adoption of the compensation law, when one of the employees of these factories was injured, he came to the hospital and was treated. The hospital was not paid for the service rendered, the factory lost the services of its employee for a

*Read before the American Hospital Association at its nineteenth annual session, Cleveland, September 11-14, 1917.

longer or shorter period, and its owners were in constant fear of damage suits, but the brunt of the burden fell upon the one least able to bear it—the injured man.

Now this is all changed. The hospital is paid for its work, the employer is covered by insurance and has no fear of damage suits, the injured employee demands and receives, as his right, proper surgical and other attention, and, if he is incapacitated beyond two weeks, gets two thirds of his regular wages. The burden has been shifted to you who wear the clothing, as the manufacturer in determining his costs and selling prices now includes his workmen's compensation premium with his other items of expense. When distributed in this way the cost of accidental injuries is scarcely felt by anyone, whereas under the old law great hardship was unjustly inflicted upon unfortunate working people.

Under the old common law system, when an employee was injured in the course of his employment, his only recourse was to bring suit against his employer for damages on the ground that the accident was due to the employer's negligence. The results of this system were extremely unsatisfactory, and there gradually grew up a realization that these old employers' liability laws were a prolific source of disagreement, dissatisfaction, and hostility between employer and employee.

The employee was ordinarily in no position financially, particularly in view of his accident, to bring suit. Furthermore, a workman dislikes to go to law with his employer unless he is prepared to seek employment elsewhere. Accordingly, he either compromised at an inadequate figure or was induced to bring suit by unscrupulous lawyers (ambulance chasers), who retained for their services a large share of the award. These old liability laws were entirely satisfactory to lawyers, but distinctly unsatisfactory to employers, employees, hospitals, and physicians.

When the employer carried liability insurance under the old system, the insurance companies were loath to allow the case to get into court, and sought by every means, fair and unfair, to secure a settlement before court proceedings were begun. This led to many abuses, and there was much dissatisfaction on the part of employees, who generally believed that they were cheated out of about 90 percent of what was due them.

Workmen's compensation, as applied to the workman and his dependents, is an attempt to substitute justice for charity, and it gives him a certain feeling of security and freedom from worry. As applied to the employer, it relieves him of the uncertainty of a court decision, and enables him to figure almost exactly what it will cost him to provide for his injured employees, and to pass this cost on to the ultimate consumer. As applied to the hospital, it means increased income and consequently greater opportunity.

It is becoming apparent that compensation laws will operate to decrease industrial accidents. While the acts do not emphasize it, the element of conservation is one of the most important results of the system. Employers generally are installing the most modern and accident-proof machinery obtainable, for they now recognize the importance of preventing the occurrence of industrial accidents. When employers are remiss in this respect, their insurance carriers will apply corrective measures, such as a low schedule rating with a consequent high premium.

Employers and insurance carriers cannot now afford to give inadequate care to injured employees. They know that neglect or unskillful treatment may result in the injured employee becoming a permanent pensioner. Under the old law, the employer and the insurance company feared the unscrupulous lawyer; under the new law, they fear the dishonest or incompetent doctor.

It is to be expected that employers with their first-aid rooms and hospitals and insurance carriers with their staffs of paid physicians will take a considerable amount of work away from the regular hospitals, but the hospitals will still have plenty to do. It is conservatively estimated that the number of industrial accidents resulting in death in this country is about 35,000 annually, and the number of non-fatal injuries exceeds 500,000. Most persons suffering from minor injuries rush to the nearest hospital, and those who are severely injured are brought in in our ambulances.

Traumatic surgery is coming to be regarded as a most important branch of medicine, largely owing to the war, but partly owing to workmen's compensation laws. At the present time the most competent surgeons in the world are devoting their attention to it on the battlefields of Europe. From them we are hearing much about the preventing or aborting of infection by means of chemical sterilization. Those who have studied this treatment believe that it has possibilities as a limb-saver and a time-saver. The new paraffin treatment of burns is also favorably commented on. If these innovations accomplish nothing else, they will at least prove an important factor in directing attention to the need for better treatment of industrial injuries.

Industrial surgery in the past has not always received from hospitals and doctors the consideration to which it is entitled. Much of this work has been poor and the results have been bad. We hospital people know that this important work has

been often entrusted to the least experienced interns. Continuous progress in this line of surgery may now be confidently predicted.

While we admit that hospitals are going to have aggressive competition in this field, which, after all, is an excellent thing, yet we believe that the future advancement and progress in industrial surgery, now that its importance is becoming recognized, will come largely through their efforts.

When the workmen's compensation law went into effect in New York, one of the first difficulties we encountered was in the establishment of equitable ward rates and in securing an acceptable schedule of professional fees. The act does not limit the amount which shall be paid for treatment during the statutory period of sixty days, but the insurance companies were naturally anxious to keep down medical fees and hospital expenses. Finally, at a meeting attended by representatives of the workmen's compensation commission, the hospitals, and the insurance carriers, it was agreed that a ward rate of $2.25 per day was reasonable, and it was further agreed that for ambulant cases $2 should be charged for first treatments and $1 for subsequent treatments.

A medical and surgical fee bill which had been approved by a committee of the Medical Society of the State of New York and by the New York Claim Association was tentatively accepted by the hospital representatives. The New York Hospital still bases its charge on this schedule, and we presume that most of the other hospitals do likewise, but we understand that the state medical society disowns it and refuses to recognize it officially. Under this schedule the largest fee allowed the surgeon is $75, which includes first aid, operation, and full subsequent treatment. This is a small fee, but, when it is recalled that formerly the surgeon usually received nothing for treating these patients, it is not so bad.

Our next difficulty arose when we came to discuss the division of fees between the hospitals and the doctors. No plan acceptable to all concerned was devised by the committee, and now after three years have elapsed there is no uniformity among hospitals in this respect.

In some instances the hospital retains all fees, the doctors evidently conceding that the hospital's needs are greater than theirs. This plan is not approved by the insurance companies. They prefer to have the professional fees go to the doctors, as they believe the doctors will take more interest in these industrial accident cases if they receive some compensation for their services.

Other hospitals, particularly those situated in residential districts where there are few accident cases, refer all ambulant compensation cases to the offices of their visiting staffs. The insurance companies object to this plan. Their claim is that the patient rarely goes to the doctor to whom he is sent, but to one of his own selection, who may be dishonest or incompetent.

Some hospitals retain the $2 fee for the first treatment and turn over the fees for subsequent treatments to the doctors who actually do the work. Others retain a certain percentage of the fees—10 or 15 percent—to cover the cost of dressings, the remainder being paid to the doctors.

At the New York Hospital the question of division of fees was happily settled when it was decided to pay small salaries to all out-patient physicians, a policy which had long been under advisement. These out-patient men take care of practically all the subsequent treatments, and also all new patients applying between 10 and 12 o'clock in the morning. The admitting physicians, who are salaried men, are responsible for first-aid treatments at all other hours, but the interns do much of the actual work.

Our hospital retains all workmen's compensation fees, except in the case of ward patients; in these cases the professional fee is turned over to the attending surgeon. In addition to the charge of $2.25 per day, the hospital collects and retains fees for x-ray work and for the use of the operating room. Crutches and other appliances and special nursing are also charged to the employer.

The New York Hospital and the House of Relief are located in districts where industrial activity is great, and it early became apparent that to handle efficiently the additional clerical work occasioned through the operation of the workmen's compensation law, it would be necessary to increase our clerical force. Accordingly, two clerks were assigned to this work exclusively. They are practically in complete charge of it, and it is regarded as a regular department of the hospital. If this work had been left to the regular clerical staff it would have been neglected and the hospital would have lost heavily.

The compensation clerks are much appreciated by the commission and the insurance carriers, as they know they can always depend upon these clerks for prompt and authentic information regarding their cases. Incidentally, the clerks relieve the superintendent and the doctors of a lot of troublesome details.

Some hospitals report that they have trouble in getting their physicians to fill out and sign certificates required by the commission and some of the insurance companies. At the New York Hospital these forms are filled out by the compensation clerks and signed by the superintendent. This we find to be much more satisfactory administra-

tively, and so far no exception has been taken to our method.

When a patient comes to the emergency room for first treatment, the nurse on duty enters his name, address, occupation, name and address of employer, together with the diagnosis and date of treatment, in a book kept for this purpose. The patient is given for his keeping a card which identifies him as a compensation case. He is also given instructions about reporting for subsequent treatments.

We treat subsequent cases in the out-patient department, not because we regard them as charity patients, but because it is the only available place we have.

When the patient applies at the out-patient department for his first subsequent treatment, he is referred to the desk of the compensation clerk, who has on file a card bearing the information obtained by the nurse on the patient's first visit to the hospital.

The clerk has already notified the employer by means of a form letter that the patient has applied for treatment. In this letter we endeavor to impress upon the employer the necessity of promptly reporting the accident, and suggest that he furnish the hospital with the name of his insurance carrier, thus enabling us to take the matter up direct with the carrier without further annoyance to him. Information is also given as to our charges. Replies are received to about 80 percent of our letters, and 10 percent are returned by the post-office department as undeliverable on account of defective addresses. As the New York law requires that treatments by hospitals or doctors shall be authorized by the employer, these letters are of importance in a legal way. If the hospital can show that the employer acknowledged receipt of the letter and gave instructions regarding billing, a legal claim for services can easily be established before the commission.

The compensation clerks keep informed regarding the condition of every patient, and if one does not report for treatment regularly his employer is notified. Employers appreciate this attention.

Efforts are made to prevent patients from returning oftener than their condition demands. Insurance companies appreciate this attention. We rarely find it necessary to treat ambulant cases oftener than three times a week.

First treatments are, of course, given at any time, but subsequent treatments are given during only one hour each day.

When treatment is completed, an itemized bill is sent at once, either to the employer or directly to the insurance carrier. A large percentage of the bills are paid promptly, but there are many which have to be followed up four or five times before a remittance is received. An efficient follow-up system is essential. Probably a personal visit to the employer would hasten payments. We do not allow our attending surgeons to send out separate bills, as this would result in complications and delayed payments.

For a year after the law went into effect, a great amount of difficulty was experienced in obtaining payments. This was due largely to the fact that many employers were not aware that the law existed, or hoped to evade it, and failed to take out insurance; or, if they had insurance, they neglected to report their accidents. They have now learned the importance of carrying insurance and of reporting their accidents.

The New York act stipulates that the employer must provide such medical and surgical aid, nurse and hospital service, medicine, etc., as may be required during the first sixty days after the injury. When a patient's treatment originates in our hospitals, we, of course, care for him as long as his condition requires it, regardless of the statutory limit. Frequently cases are referred to us for treatment after the sixty-day limit has expired. In these instances we feel justified in insisting upon a definite understanding regarding payment for our services. As a practical business proposition, the insurance companies frequently pay for medical treatment and hospital care beyond the statutory limit, as by so doing they shorten the period of disability, and thus reduce the payment of compensation.

While it sometimes happens now that patients are taken away from the hospitals by doctors employed by the insurance companies, still the hospitals of New York are gradually increasing their compensation work. At the New York Hospital this work is confined largely to the care of ambulatory cases, from 75 to 100 being treated daily. Formerly at least 95 percent of these cases were treated free.

The New York act contains a clause exempting from its provisions persons not employed for the pecuniary gain of their employers. As hospitals are not conducted for the pecuniary gain of their managers, it would appear that their employees did not come under the provisions of the act. But as certain occupations, such as engineers, electricians, mechanics, painters, laundrymen, and laundresses, are specifically mentioned as coming under its provisions, the hospitals were in somewhat of a dilemma. They did not know whether to insure under the law or not. As a matter of fact, very few did insure under it, preferring to retain their old liability policies. But the last leg-

islature came to their assistance with an amendment to the law enabling the employer and employee by joint election to come under the law if they so desire.

The New York Hospital then decided to take out this form of insurance. Under the policy issued the insurance company agrees, among other things, to inspect the hospitals from time to time and to suggest such changes and improvements as may operate to reduce the number of personal injuries. Inspections by competent inspectors and safety engineers such as the insurance companies employ are of considerable value. In our case they made several excellent recommendations, especially in connection with the laundry machinery.

One of the largest corporations in this country which had been carrying its own compensation insurance recently took out a policy with an insurance company largely because it wanted to have its plants periodically inspected by competent inspectors not on its own pay roll.

Workmen's compensation insurance apparently gives greater protection to employers than does ordinary liability insurance, and is more satisfactory to the employees. It simplifies hospital insurance and fixes responsibility.

The premium cost is based upon the entire remuneration during the term of the policy of all employees, except that no premium charge is made for any portion of the salary of any officer in excess of $1,500 per annum. The premium charges on a hospital pay roll are as follows:

$0.08	per $100.00 on the clerical pay roll,
0.232	on the professional,
1.32	on the laundry,
1.95	on chauffeurs and helpers, and
0.568	on the pay roll of all other employees.

It is necessary that the pay roll shall be kept to show the different classes in order that at the end of the year an audit by the insurance company may be made to determine the actual premium. If the original premium was excessive a return will be made by the company, but if it was not sufficient the hospitals will be required to make up the difference.

There is a provision of this insurance policy of peculiar interest to hospitals. It specifies that any employer may assume the responsibility of medical attendance for the statutory period of sixty days, for which there is a reduction in premium of 17.5 percent. Most hospitals will probably elect to assume the responsibility for medical attendance. The New York Hospital reduced its premium $400 by doing so.

In this paper we have dwelt largely on the New York act for the reason that it is the only one with which we have had practical experience. The New York act is not ideal, but apparently it is fairer to hospitals and physicians than are the laws of many other states. The insurance companies, however, assert that the indemnities provided by it are excessive to such an extent as occasionally to convert injuries into sources of profit. It is difficult to please everybody. An attempt will be made to amend the New York act "to cover all occupations except possibly farming and domestic service; to include occupational diseases as well as accidental injuries; to reduce the waiting period from fourteen to seven days; and to require medical service during the entire period of disability."

There are certain peculiarities of the compensation laws of other states which are worthy of mention. The New Jersey law provides that in no case shall the combined bills of the hospitals and physicians exceed $50, and the indebtedness must be contracted within the first two weeks after the injury. This allowance is ample for the majority of minor injuries, but for many cases of major injuries it is manifestly inadequate. If the hospital bill reaches $50 the doctor gets nothing but the experience of caring for the case.

In Maine $30 is about the limit hospitals can expect to receive. Some of the hospitals of that state have adopted, in self-protection, the plan of not recognizing the insurance companies when it comes to the matter of settlement, dealing either with the employer or the injured man. This would appear to defeat the intent of the law.

The Pennsylvania act is not satisfactory to either hospitals or physicians. So far attempts to amend it have been unsuccessful. It provides a sum not to exceed $25 for medical and hospital care for the first fourteen days, unless a major operation is performed, when $75 is allowed. This allowance is too small and the period of liability too short. Another defect in the law is that corporations cannot be held liable for medical services unless the injured employee is attended by a physician designated by them. As it frequently happens that the company physician, for one reason or another, does not command the confidence of the employees, this provision is distinctly objectionable and unfair to them.

The Rhode Island law goes to the other extreme and gives the injured employee the exclusive right to select a physician. It is a reasonable question whether it is fair to the insurance company and employer not to allow them any voice in the selection of physicians. Conceivably a too sympathetic family physician, or an unscrupulous one, and a patient given to malingering might cause an insurance company no end of trouble and expense.

The Maryland act limits maximum liability to

$150, but it is hoped to increase this limit to $300. The Hospital Conference Association, recently organized, has succeeded in effecting an arrangement whereby the hospital bill is paid before that of the surgeon. If the hospital bill amounts to $150, the surgeon gets nothing. This is a little rough on the surgeon, but the hospital has been put to actual expense by the presence of the patient, whereas the surgeon has not. The conference also succeeded in having the hospital ward rate increased from $1 to $1.50 a day. Compensation cases are not regarded as charity patients, and the hospitals should be reimbursed at least to the extent of the average cost of caring for ward patients, which is certainly more than $1.50 a day.

The acts of Alaska, Kansas, New Hampshire, Washington, and Wisconsin do not provide for medical attendance, a serious oversight.

In Indiana, Kentucky, Maryland, New York, and Oklahoma, the charges of physicians and hospitals are not enforceable under the law unless approved by the compensation board or commission. In New York this has not proved a serious defect.

In California and Massachusetts, occupational diseases are included as personal injuries entitling the employee to compensation.

Judging from the letters we have received and the comments we have heard, there appears to be considerable dissatisfaction with the compensation laws in various states. Hospitals and doctors are not the only ones who are protesting. Numerous complaints are heard from insurance companies and employers. This is not surprising when we pause to consider the phenomenal rapidity with which these laws have been placed on statute books all over the world. It is not to be wondered at that mistakes have crept in and that there has been such a general lack of uniformity in the acts of the various states. The law is in a formative stage, and it is too early to expect perfection. Undoubtedly a few years hence it will deal more justly with all concerned, providing, of course, that constant agitation for its improvement is kept up by interested parties, and the present indications are that it will be. There is already evidence that the protests of physicians and hospitals are not without avail. Within the past few months six or eight states have amended their compensation acts to provide more liberally for both. While doctors and hospitals object strenuously to many of the fee schedules and to some of the administrative details, yet the majority readily concede that the fundamental principles of the law are unobjectionable and in harmony with present social and economic conditions.

The insurance companies maintain in New York City a "Workmen's Compensation Publicity Bureau" for the purpose of advancing and protecting their interests under the law. We do not advocate that the American Hospital Association shall maintain a similar bureau, but merely mention the fact to illustrate how big business meets problems of this magnitude.

The Opportunities and Needs of County Tuberculosis Sanatoriums

Dr. Leo G. Guyer describes in the *St. Paul Medical Journal* the work of the Minnesota county sanatorium system (also described by Robinson Bosworth in THE MODERN HOSPITAL for March, page 182). He says that provisions of the Minnesota law allowing state aid for both construction and maintenance have done much to encourage many counties to take definite steps toward hospital provision. During the two-year period preceding the announcement that the fund for new buildings was exhausted, thirty-two counties applied for and were qualified to receive state aid. Dr. Guyer adds: "There is, perhaps, no more important factor in the care of the tuberculous than training and instruction. No other patient requires training so much as does he; no other patient is in better position to take training and education. The typhoid patient is too sick to care about anything but his headache, or, in his convalescence, too hungry to think of anything but his appetite. The pneumonia sufferer is too busy breathing to give thought to anything but the pain in his side. But the consumptive is well 'from his neck up.' He has time to think about everything, has time to worry about everything, and he has time to do about everything—foolish and detrimental. He must, therefore, be instructed, trained, educated. He must know the truth about himself, at least sufficiently enough to recognize the gravity of his condition. He must learn to watch himself, for he cannot at all times have a nurse or physician at his call. He must be prepared for emergencies, such as hemorrhages, fever, etc. The consumptive needs nearly everything in the field of medicine—nursing, dentistry, surgery, medicines, hygiene, dietetics. He needs treatment for what is the matter with him. Let us give it to him!"

These, then, may be called the eight fundamental principles of public health nursing:

1. That only well-trained nurses should be employed.

2. That the nurses should not be distributors of material relief.

3. That there should be no interference with the religious views of the patients.

4. That the rules of professional etiquette should be rigidly observed.

5. That cooperation in all its forms should be recognized as of primary importance.

6. That suitable and accurate records should be kept.

7. That patients unable to pay for nursing care should receive free service, and that those able to pay for it should do so according to their means.

8. That the daily working hours of the nurse should be limited, in order that good work may be done and they themselves be kept physically well.

This number or classification of fundamentals is by no means final. Each year brings changes and developments undreamed of in the beginning, and requiring adaptability of method and administration if progress is to be made.—Mary S. Gardner, "Public Health Nursing."

ADDISON COUNTY HOSPITAL, MIDDLEBURY, VT.

A Home-like Hospital Set Amid Historic Scenes—Provision Made for Enlargement to Meet Future Needs

BY HARRY LESLIE WALKER, ARCHITECT, NEW YORK CITY

THERE is at the present time no general hospital in the State of Vermont between the town of Proctor on the south and the city of Burlington on the north, and this building is intended to provide facilities for caring for the sick in the town of Middlebury and the surrounding country comprised in Addison County. Situated in Middlebury is Middlebury College, a rapidly growing institution with many fine modern buildings and an honored history reaching back to Colonial times. Here is gathered a large group of young men and women coming from all over the United States and who at the present time are provided with no hospital facilities whatsoever. A generous friend has offered to give 25 percent of the cost of the building and it is expected that before very long the remainder of the necessary funds will be provided.

Fig. 1. Addison County Hospital, Middlebury, Vt.

Owing to the lack of precedent and data as to the possible future use of the hospital it has been thought best to provide an administration and operating equipment ample enough to care for a considerably larger number of beds than are at present planned for. The administration has

Fig. 2. Addison County Hospital, Middlebury, Vt. Basement floor plan.

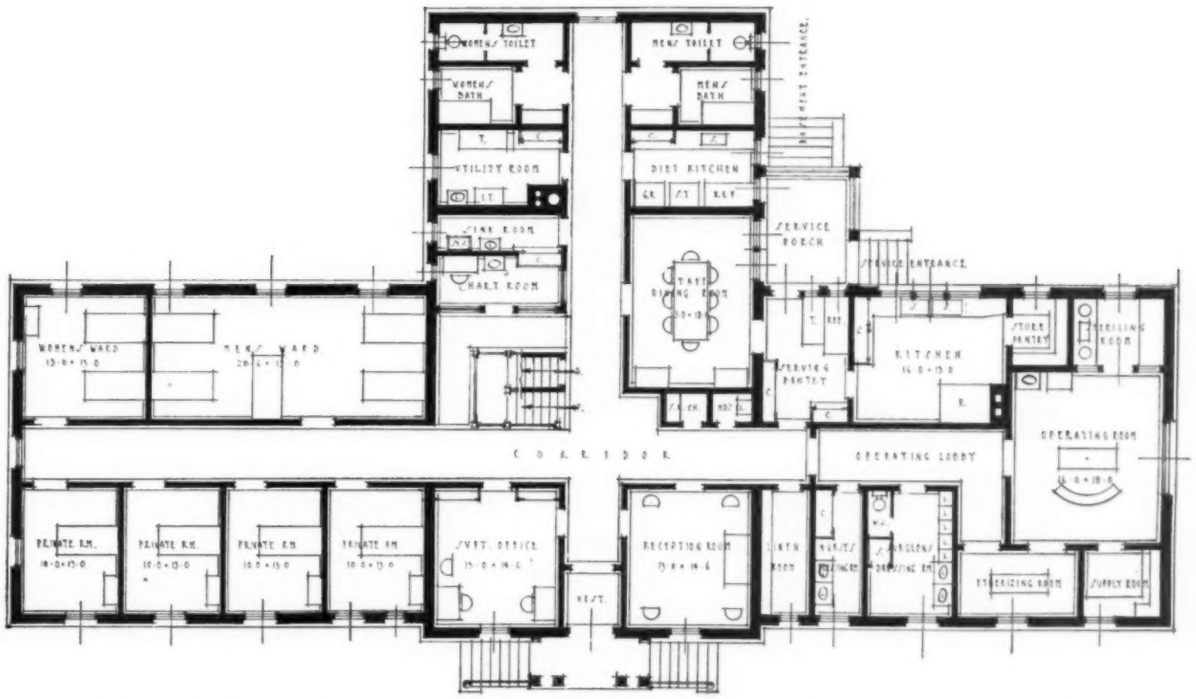

Fig. 3. Addison County Hospital, Middlebury, Vt. First floor plan. Entire women's ward and private room wing to be added at rear.

been placed in the center with the operating suite on the north end of the front of the building.

The south end of the front has been planned to provide for eleven beds arranged so that at first both men and women may be cared for in this wing.

The central portion has been made two stories high, thus providing rooms in the same building for six nurses and two maids, with their respective bath rooms. As the institution grows, these rooms might be used for convalescent patients and the nurses cared for in a separate building.

The future wing will be built extending from the center of the rear of the present building, thus bringing the beds into proper arrangement with the administration and utility rooms already provided in the central portion of the plan. When this is done the divisions in the south wing will be removed and this end of the building given over to men patients, while the new wing will provide for the women.

At present the plan provides for eleven beds, not including the possible ones in the second story, but the operating, utility, and administration facilities are ample for thirty or thirty-five beds, which would probably be well over the ultimate needs of the community served.

In the basement are arranged the boiler and fuel rooms, laundry, janitor's room with toilet, patients' clothes room, laboratory, drug room, disinfector room, room for future x-ray apparatus, and numerous individual spaces to be used for storage or other purposes as the needs may arise.

The first story of the building has the superintendent's office on one side, and the visitors' reception room on the other side of the main entrance. In the south wing are the patients' rooms, in the rear of the central portion the utility rooms

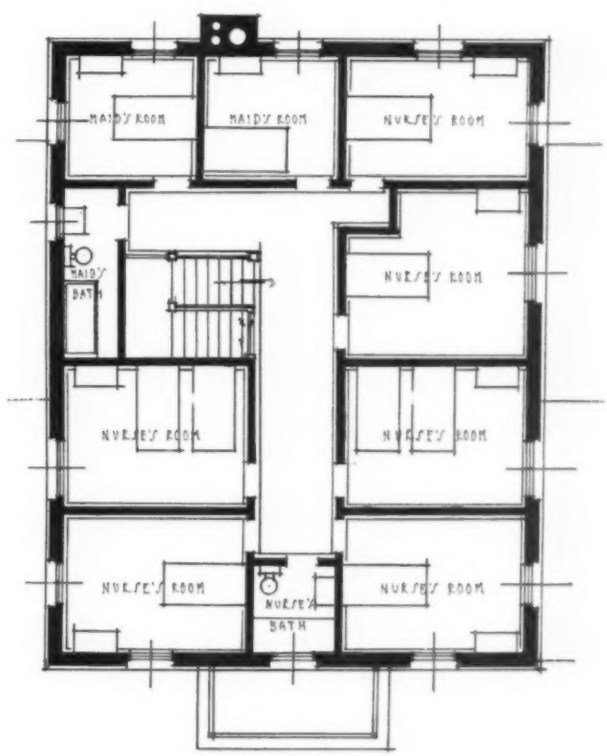

Fig. 4. Addison County Hospital, Middlebury, Vt. Second floor plan.

and staff dining room, and in the north wing is the operating suite. The rear entrance and service porch are placed in the northwest angle of the building, and from this porch ice may be placed in the refrigerators of the diet kitchen and the main serving pantry, without bringing it through the building.

The exterior is treated as a simple Georgian building, the walls being of hollow terra cotta blocks covered with stucco. The roof is of green slate and there are green shutters at the windows. The basement wall is of rough red brick and all of the porch and cornice woodwork is painted a warm gray, slightly darker in tone than the stucco. An effort has been made to handle the design of the exterior of the building so that it shall have a distinctly domestic character, in keeping with the surroundings in an old New England town. The ideal hospital building is essentially a home where the sick become well, and the small town hospital should, especially as to its exterior design, be kept as far as possible from the usual institutional character.

The interior is of non-fireproof construction with wood floors, excepting in the baths, toilets, and operating suite, where tile floors and wainscoting are used. The plumbing fixtures are of solid porcelain and of the latest design, and the heating system is a low-pressure gravity system with a separate tank heater for domestic hot water and a small high-pressure vertical boiler furnishing high-pressure steam for sterilizing purposes.

The estimated cost of the building, including architect's fees, is $45,000, which is approximately 30 cents per cubic foot.

THE PUBLIC HEALTH WORK OF A CHILDREN'S HOSPITAL

The Children's Hospital of Philadelphia Assumes Its Share of Responsibility for Educating the Public—The Department for the Prevention of Disease Works Through Clinics, Classes, and Visiting Nurses and Dietitians

By CHARLES V. DORWARTH, M. D., Physician to the Health Clinic The Children's Hospital of Philadelphia

THE idea is not new that a large percentage of deaths in infants and children is due to preventable disease. Educational methods are accepted as affording the most practical means of curtailing this unnecessary loss of life.

The Children's Hospital of Philadelphia has assumed its share of responsibility of educating the public by organizing a department for the prevention of disease.

This work is carried on in the thirtieth ward, which is a thickly settled residential section having a population of 29,000, including a large proportion of negroes. It covers an area of 0.519 square mile. In 1915 there were 562 births in the ward—a birth rate of 19.24 per thousand.

The department as organized includes the following:

1. A prenatal clinic.
2. A health clinic.
3. A physical development class.
4. Two visiting nurses.
5. A visiting dietitian.

THE PRENATAL CLINIC

The last report of the Federal Children's Bureau shows that in one year, in this country, 15,000 women died from conditions caused at childbirth, more than one-half of which are now known to be preventable. No estimate is made of those who survived only to suffer from a degree of preventable ill health.

The prenatal clinic sees to it that expectant mothers are properly cared for, so that they may bear healthy children and come through childbirth in good physical condition, able to nurse their babies. Many babies who need not have been bottle-fed are brought to the hospital for "regulation of feeding."

In the prenatal clinic the obstetrician in charge examines and reexamines each expectant mother at regular intervals. The blood pressure is estimated and urine frequently examined. He confers with the patient as to her habits of life and gives her instructions as to her personal hygiene.

The nurses repeat these instructions as they visit their homes and make it possible for the patients to carry out the physician's orders. The nurses report to the obstetrician on the living conditions, and the decision is then made as to whether home or hospital maternity service is to be provided. Nurses make arrangements for confinements.

As the report of the United States Census Bureau shows that 300,000 babies died before they were one year old, in 1914, it is important that the newly born babies be brought to the health clinic as soon as possible, so that the mothers may be instructed how to safeguard them in every possible way against the many dangers that threaten their health.

THE HEALTH CLINIC

The parents who bring their well children to

this clinic are taught how to keep them well. When a child is brought to the health clinic, the parent is first interrogated regarding the health of the applicant. If the child is well, admission to the waiting room is granted. There the clothing is removed and the weight and various measurements are ascertained. A complete physical examination is then made.

When there are indications that a further examination of the eyes, ears, nose, or throat is needed, the child is referred to that particular dispensary. When an organic lesion is discovered, the patient is sent to the medical dispensary for treatment. It is surprising to see how few of the children examined meet the requirements of a normally developed child. Malnutrition and lack of muscular development are commonly found. Existing social conditions often making these difficult to combat.

Patients discharged from the hospital are referred to the health clinic unless they return to their own physicians, or unless they are still in need of surgical or medical care, in which case they are referred to those dispensaries. Mothers are encouraged to bring all their children to the clinic for examination and advice.

THE PHYSICAL DEVELOPMENT CLASS

The object of this class is to assist any child who is not making normal physical progress to do so. Children whose muscles are relaxed, whose posture is poor, whose chests do not expand well, whose general nutrition needs to be improved are sent to this class.

The method used is either exercise or manipulation given to each child individually. The children thus acquire a more general use of the entire muscular system, resting the overworked muscles and bringing into play unused muscles. The nurse who observes the instructor as he gives the exercises in the hospital visits the homes to see that the mother properly supervises the children as they exercise.

VISITING NURSES

Many of the most serious cases seen in the hospital wards are the result of the parents' ignorance of the laws of health. The nurses visit the families in their homes and become their confidential friends, learning their innermost problems. When this problem is a financial one, the nurse learns the cause and endeavors to remedy it; when it is improper sanitation, it is reported to the proper authorities for correction. When another member of the family is ill, the nurse refers the patient to a hospital. She explains the physician's orders and sees that they are carried out. She also makes arrangements for convalescent care of children who no longer need hospital care, but who are not strong enough to go home. She teaches the mother the importance of cleanliness, the value of fresh air and regular habits of living. If she encounters suspicious cases of contagious disease they are referred to the bureau of health for observation.

A VISITING DIETITIAN

The importance of a well-regulated diet is not appreciated by all mothers. They do not consider the nutritional value of food; to them the only object of eating is to satisfy hunger. The children eat what they want, and eat when they want to. As a result we find malnutrition, severe gastro-intestinal disorders, and other conditions which undermine their health. The visiting dietitian teaches the mothers to purchase food suitable to their needs and within financial limitations, and how to prepare it. She explains the importance of regular habits of eating.

It has been the experience of our dietitian that in many of the families visited the diet has been too one-sided—too much fat, carbohydrate, or protein. Sometimes the quantity of food is too small. The visiting dietitian reports these conditions to the physician at the clinic and consults with him; a diet is then ordered that will meet the requirements of the patients.

A resident physician and nurse have been assigned to the department for the prevention of disease, to assist in the health clinic. Volunteer workers, clinical secretaries, and clerks have also assisted in the health clinic.

Two troops of Boy Scouts have acted as inspectors of stables as a part of a campaign against flies. They have secured the cooperation of the stable owners in complying with the law as outlined in the manure ordinance. Their work has proved most successful, as shown by the improved condition of the stables.

Lantern demonstrations have been given to the public upon various phases of infant and child life, and upon hygienic and sanitary subjects.

Miss Geraldine Borland, R. N., formerly superintendent of the Hanover Hospital, Milwaukee, has lately taken up the work of superintendent of nurses at the General Hospital, Kansas City, Mo.

Dr. C. W. Larrabee has reopened his private hospital at Helen, Ga., following the installation of new equipment, including an up-to-date x-ray outfit. Dr. Larrabee believes he now has one of the best small hospitals in the South. Twelve patients can be accommodated.

INDUSTRIAL HOSPITAL MANAGED BY EMPLOYEES

Missoula (Mont.) Institution Built and Operated by Benevolent Organization of the Northern Pacific Railroad—Formerly Conducted by Road Itself

By H. B. SMITH, President Northern Pacific Beneficial Association

THE first hospital of the Northern Pacific Beneficial Association, on the Central Division, was built by the Northern Pacific Railway Company in the early eighties and was later acquired by the Northern Pacific Beneficial Association. It was located in Missoula, in one of the beautiful valleys of western Montana. The grounds comprise a city block, located close to the foothills. Trees were planted at an early date, so that the site is now entirely surrounded by large trees. Flowering shrubbery and roses border the lawns, every advantage having been taken to beautify the surroundings.

In 1892 the original building was destroyed by fire, to be replaced the following year by another of similar construction. An addition to accommodate forty patients was constructed in 1902, this being also nonfireproof. The following year a small detention building was added to the group, to handle contagious cases. The nurses' home was built five years later, followed the next year by the laundry; a modern heating plant with two 100-h. p. high-pressure boilers was erected in 1913. Of the group, the nurses' home, laundry, heating plant, and detention ward will be retained, but the main hospital building is now being replaced by a modern fireproof structure. The home of the chief surgeon will be erected soon after the main building is constructed.

Industrial Hospital of the Northern Pacific Beneficial Association, at Missoula, Mont.

The hospital building and grounds belong to the Northern Pacific Beneficial Association. The hospital has a restricted staff. The chief surgeon has general supervision, with one assistant and two interns. The present nursing staff consists of seven graduate nurses and three experienced male nurses.

Hospital benefits are confined strictly to members of the Association, although dependent members of families of those belonging to the association may be admitted to the hospital, as pay patients, at a nominal rate, should accommodations permit.

Upon the recommendation of the president, a committee from members of the board of managers was appointed to investigate the situation as to the construction of a new building, and upon the recommendations of this committee the board decided to construct a modern fireproof building immediately, authorizing an appropriation of approximately $125,000 for this purpose.

In May, 1916, final plans for the building were submitted by Mr. Bassindale to the board of managers and accepted. Subsequently a number of minor changes have been made, but for the most part the construction will follow the original plans. Bids for construction were opened late in June, the contract for the general contract work being awarded to Olson & Johnson Company; heating and plumbing to the James Smyth Company, of Spokane, and electric work to the A. Hubbard Company, of St. Paul, Minn.

The wing which was added in 1902 has been retained temporarily for hospital purposes; the remainder of the main building has been razed. On completion of the new building the wing will also be razed. No marked changes will be necessary in the walks or entrances to the grounds, as the new building occupies the same location as the part torn down.

The new building will accommodate 72 patients, and, to allow for some increase, the sun rooms will be so arranged that they can be converted into wards, making a total capacity of nearly 100.

The building will be fireproof throughout, basement of concrete construction, first floor Bedford stone, and the remaining three floors brick, with

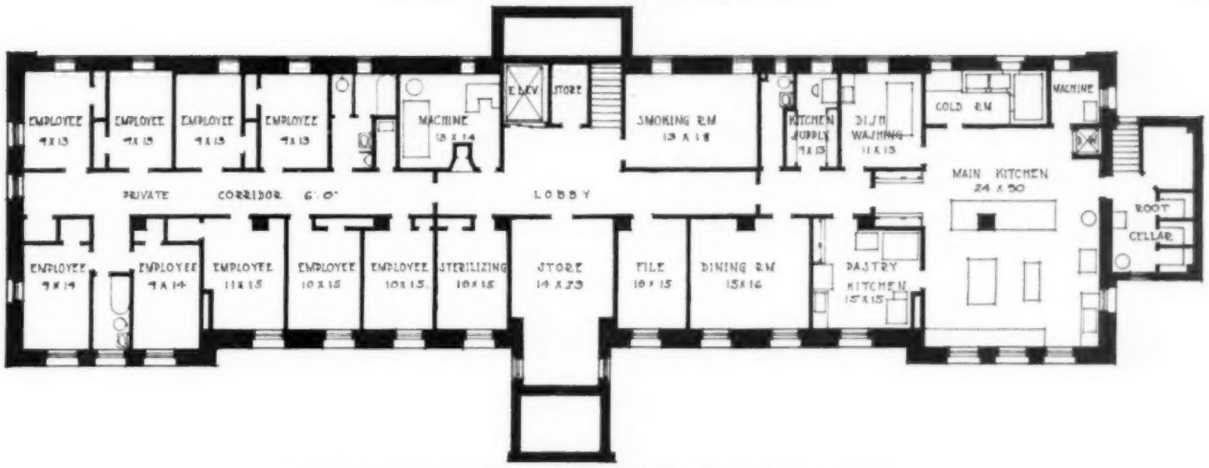

Fig. 1. Northern Pacific Beneficial Association Hospital. Basement plan.

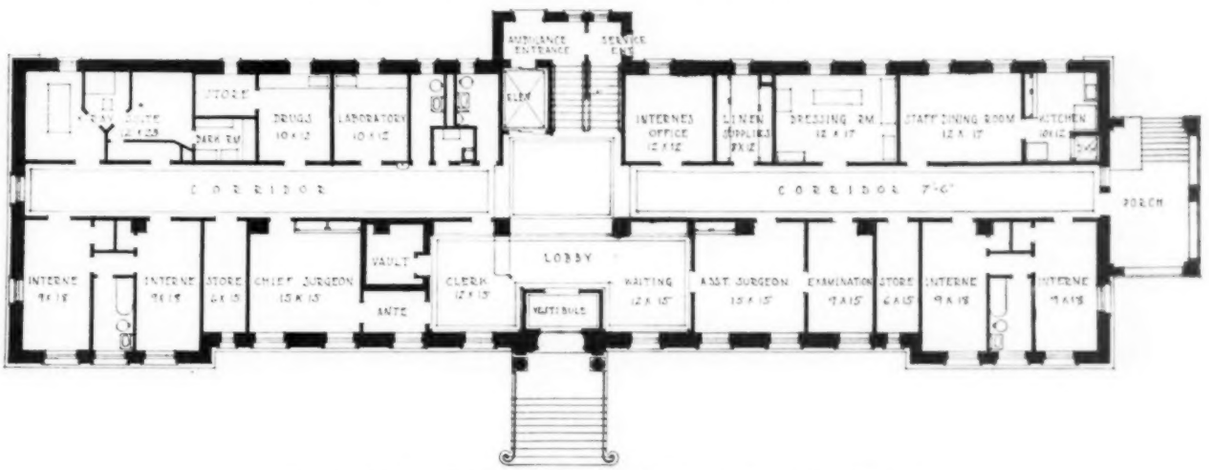

Fig. 2. Northern Pacific Beneficial Association Hospital. First floor plan.

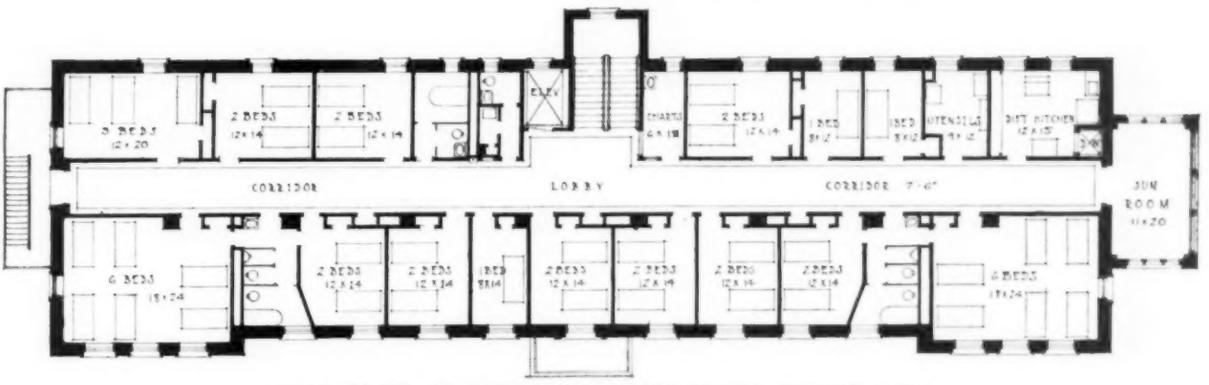

Fig. 3. Northern Pacific Beneficial Association Hospital. Second floor plan.

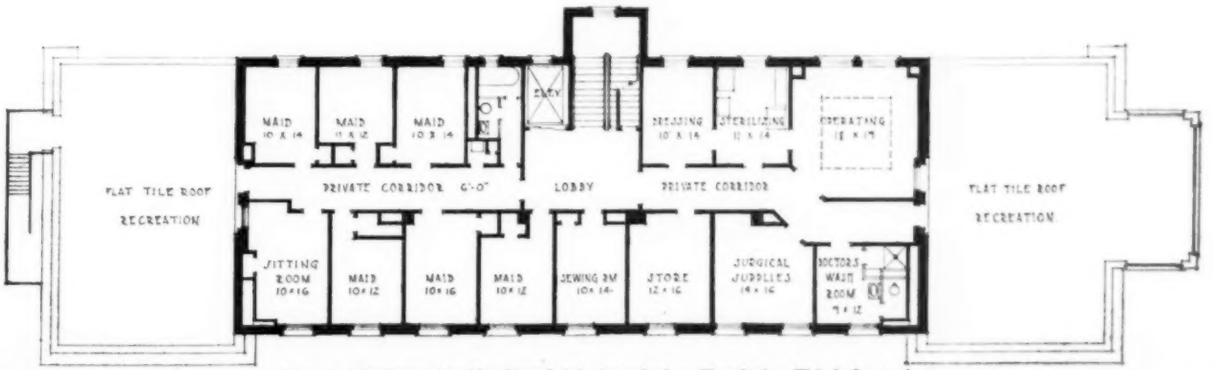

Fig. 4. Northern Pacific Beneficial Association Hospital. Third floor plan.

tile roof. About one-third of the building has flat roof, covered with flat roofing tile and surrounded by high parapet. This roof is to be used for recreation. All floors, except a few store rooms, are of terrazzo. Plaster walls and ceilings are treated with enamel paint, and sanitary metal door frames are provided.

Every effort has been made to arrange each floor and department in the most convenient manner in order to save time and labor throughout. All departments will be connected with intercommunicating telephones, with outside connections on each floor. All rooms and wards will have silent signals to the chart rooms. All floors will be served by electric passenger and service elevators, from main kitchen to all floors. In the basement are located main kitchen, store rooms, smoking room, help's dining room, disinfecting room, rooms for male help, bath, and laboratories, all well lighted and ventilated.

On the first floor are the office, administration department, staff dining room, x-ray room, dressing room, drug room, laboratory, and intern suites.

The second and third floors are duplicates. On each of these are small wards, single and double rooms, diet kitchen, chart room, living rooms, baths, etc. At the east end of each of these floors, opening from the hall, there is a sun room, which is so arranged that it may be converted into a ward.

The operating room, sterilizing and dressing rooms, sewing room, surgical stores, and rooms for female help, such as maids, cooks, and waitresses, are on the fourth floor.

The buildings and departments which have been retained are satisfactory for present needs. The nurses' home has eight large rooms, ample storage room, and bath. The laundry has recently been repaired and refitted to some extent, so that upon the completion of the new hospital building we shall have an entire group of buildings sufficient to meet all requirements.

Oleomargarine

The term "margarine" was at first used to designate a mixture of the fats composed of such proportions of palmitine and stearine that it closely resembled margaric acid. Later, when soft beef fat or oleo oil became an important component, the mixture was called "oleomargarine" or "oleo." "Margarine" remains, however, the legal term for butter substitutes in Great Britain.

The name "oleomargarine," remarks A. D. Holmes in the *American Food Journal*, does not at present indicate the composition. The principal fats used in its manufacture in the United States are oleo oil, neutral lard (that is, a specially rendered lard), and cottonseed and other oils. All these ingredients must be pure and prepared with care in order that none of them shall have any marked taste or odor. These are mixed in such proportions as will give the final product a melting point very near that of butter. After being thoroughly mixed, the fats are churned with a small quantity of milk and sometimes cream, the proportions of these used depending upon the quality of the product desired. In the preparation of high-grade oleomargarine, varying quantities of butter are also added. The resulting product is then washed, salted, and worked as in ordinary butter-making processes. Owing to the ease with which a highly colored oleomargarine might be sold as butter, it is illegal to sell oleomargarine unless it is plainly labeled as such, and the practice of coloring it to imitate butter is discouraged by a heavy tax. Oleomargarine is not used as extensively in this country as in Europe, where it serves for both table and culinary purposes. If prepared from pure materials and under sanitary conditions, it is a wholesome fat, which, according to European investigators, is well assimilated. It has an energy value of about 3,500 calories per pound.

ST. ANTHONY HOSPITAL, CARROLL, IOWA, HAS STATE UNIVERSITY BRANCH LABORATORY

Bacteriological Work, Pasteur Treatment, and Many Other Departments of Work at State University Available in Carroll Hospital Now—Dr. Jessie B. Hudson, of Clinton, in Charge

St. Anthony Hospital has made another long stride toward becoming one of the biggest institutions of its kind in the country in the securing of the establishment of a branch laboratory of the state university within its walls. The necessary apparatus and equipment have been installed and everything is ready for business.

The work is in charge of Dr. J. B. Hudson, from Clinton. Dr. Hudson was for four years in charge of the laboratory work in the State Board of Health Laboratory, Iowa City, and her standing in this line of endeavor is well established in Iowa. She comes with the recommendation of the leading medical men of the university, is a doctor of medicine, and has a M. S. degree, and her work will make a great addition to the medical and hospital facilities of Carroll and all western Iowa.

Other towns and cities in this part of the state made a strong effort to secure the location of the branch laboratory, but Carroll was finally selected because of its central location and its excellent hospital facilities.

Besides bacteriological tests, the laboratory is prepared to give the Pasteur treatment for rabies. Work in vaccines, blood serums, and tissue work will also be done, and the diphtheria and typhoid tests of this part of the state will be brought to Carroll instead of being sent to Iowa City. In fact, the local branch is designed to relieve the university from this sort of work from western Iowa, and it also gives physicians in this section of the state much better and quicker service than they could otherwise obtain.

It should be borne in mind that this work is being done directly under the supervision of the state, that it is entirely independent of the work of any local people except that the laboratory equipment is the property of the local hospital and the work carried on in connection with it.

The new department will draw its work from all over the western part of the state, not from Carroll alone, and its chief benefit to Carroll will be in the bringing of more people to this city for treatment and the enlargement of the scope and territory of St. Anthony's.

THE FAMILY AS THE UNIT OF PUBLIC HEALTH WORK

The Instructive District Nursing Association of Boston Has Organized Home Care for Families—Some of the Results—Regeneration of Families Under the Friendly Encouragement of Visiting Nurses

By MARY BEARD, R. N., President of the National Organization for Public Health Nursing, Director Instructive District Nursing Association, Boston

THE modern public health nurse is useful just so far as she realizes herself to be concerned with the interests of preventive medicine. Indeed, I think she may claim the title of public health nurse only if she has as her first conception of her daily duties the conviction that upon her observation and foresight depends the health of the whole family into which she may be called for one or another purpose.

The family as a unit more than any one individual member of it must be her thought. Health

Fig. 1. One of the nurses of the Instructive District Nursing Association of Boston.

and how to produce it must be her effort more than the relief or cure of any one disease or defect.

Of course, the correction of defects may be the pivot upon which family health turns. The deplorable condition of teeth so universally found by public health nurses sometimes makes her sure there is no other avenue to health but the dentist's chair, but, though this may be true of dentistry and of other specialties, the public health nurse who loses the all-round view of her families in pursuit of any one object will soon limit her usefulness.

We are in the beginning of a new era. The profession of nursing after the war is over will certainly have undergone some fundamental changes. Because a universal need is making all sorts and conditions of men and women stop and think, because it has become necessary for us to take account of stock of all our resources, health and its significance has suddenly become a subject for intelligent thinking with hundreds of people who have never before had time to learn what this new public health movement means. Many people are learning now for the first time of the effort to make health as much a matter of course with American families as education has been for generations.

Mr. Havelock Ellis, in one of his "Wartime Essays," "The Nationalization of Health," says in discussing the subject of health insurance:

> "How necessary it is becoming that the extension of medicine and hygiene in the national life should be accompanied by a corresponding extension in the national government. If we had had a council of national health, as well as of national defense, or a board of health as well as a board of trade, a minister of health with a seat in the cabinet, any scheme of insurance would have been framed from the outset in close consultation with the profession which would have the duty of carrying it out. No subsequent friction would have been possible."

It is not too visionary to suppose that some such development will be a result of the mental stimulation of the present stirring times. The National Red Cross of America has been collecting millions of American dollars to be spent not only for our own soldiers and sailors and for their families, but also to be directed to the urgent needs of European countries. No part of these millions is to be spent without serious study of the particular need presented. In each instance, too, the War Council of the Red Cross will receive recommendations from a body of experts selected to make the study.

Such well-considered action will bring about the establishment of many sanitary units of various kinds, which will utilize those well-tried means and plans of health work that have for some time been proved and recognized by the few. To put it another way, publicity and Red Cross money will serve to make universal the instruments which public health officers have proved to be good and have been trying to put into use.

The most effective business men in the country have stopped everything else to bend all their powers to the consideration of spending here and in

Europe the money so terribly needed by the people. Conservation of resources means first the conservation of the health of man. When this picked group of men whose interests are now bent upon the consideration of the public health go back again to the usual pursuits of life, they will not be indifferent to the waste of life about them, and a wonderfully educated public opinion will be the result.

The modern commissioner of health has struggled long to create a public opinion strong enough to enable him to take those very measures which today he is able to accomplish without effort. Indeed, money is being put into his hands to hasten these very plans. All of which is by way of introduction to the new public health nurse on whom very much of this work rests and must rest.

She is a result of the process of evolution and was only thirty years ago a bedside nurse for "the sick poor" of our large cities. Thirty years ago the Sick Poor were entitled to capital letters and

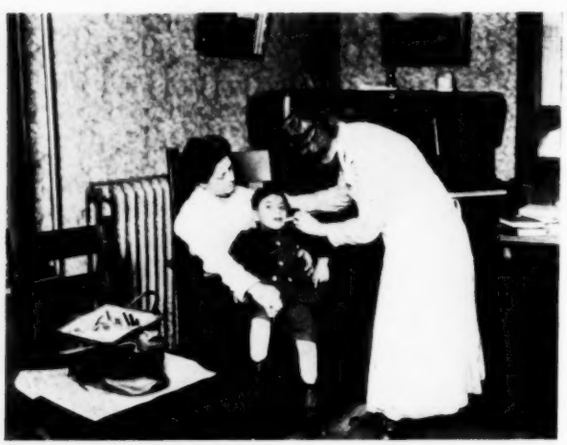

Fig. 2. In almost every home the public health nurse finds that dentistry is needed.

belonged to a class in the community utterly unlike all the other men and women. The realization that social conditions limit and control health to a great degree has given our modern legislation a new turn, as we see in the laws for mothers with dependent children, workmen's compensation laws, and the agitation for the several forms of social insurance.

But more directly modern life and knowledge has turned our bedside nurse to the colleges, there to be taught to be a "social nurse" and an instrument to accomplish the ends of preventive medicine. One large hospital (the Massachusetts General Hospital) has lately arranged a special course for young women who want to become public health nurses. The first two years in the hospital are so planned that the third year may be given up to the special study of public health nursing.

Many groups of people administer public health nursing today. Standardizing its administration is one of the things that will come quickly some day when public opinion has been still a little more roused.

At present one finds a city or state administering it, several private societies in one town will be doing each a separate phase of it, boards of education will be found directing the school nurses, and antituberculosis associations directing their separate groups of nurses.

However varied these activities may be, the true public health nurse will be found to be doing *family health work* wherever she goes and to be always observing and teaching the laws of health in order that she may prevent the inevitable disaster which follows disobedience to these laws.

The Instructive District Nursing Association of Boston publishes in its thirty-first annual report the following figures:

REPORT OF THE NURSES' WORK

From February 1, 1916, to December 31, 1916, 133,256 visits were made to 13,430 patients by 84 nurses. Of these, 699 patients met the full expense of daily visits; the Metropolitan Life Insurance Company paid for visits to 4,180 of their policy holders; 2,610 patients partly paid for the visits made to them; and nursing was given without charge to 4,659 of the very poor.

There were 2,186 expectant mothers visited periodically, examined, and advised how to prepare for the coming baby.

The number of babies and their mothers given nursing care for the first ten days of the baby's life was 1,548.

Old people and chronic invalids to the number of 1,227 were cared for.

The victims of pneumonia, bronchitis, tonsilitis, measles, diseases of the heart and other illnesses, to whom nursing care was given numbered 7,187.

There were 3,927 children on the nurses' lists. Next year this number will be still larger, for in February, 1917, the nurses added to their other work the home care of children paralyzed in the epidemic of infantile paralysis last summer. Auxiliary committees of residents have been formed in Hyde Park, Jamaica Plain, Roslindale, West Roxbury, Dorchester, Brighton, Charlestown, and East Boston, and are active in promoting the work of their districts. In the eleven months of this year the expenses have increased $5,290 over those for the twelve months of last year. This is accounted for by more patients, more visits, more records, and increased cost of all supplies. The nurses are on the watch for conditions which produce disease and for suspicious symptoms, the early recognition and treatment of which may prevent serious illness.

Seventy-two nurses have studied the special requirements of public health work under the Education Department, and have gone out to thirteen states and to Canada to make their knowledge of

practical value in the great campaign for health.

The method of organization of the work is through the branch stations, over each of which is a supervising nurse. In Ward 24, Hyde Park, we have established a health center. Hyde Park is about an hour's ride in the street cars from the center of Boston. It is a ten-cent carfare, which makes it somewhat isolated. In the station are seven nurses, all of whom have had special education as public health nurses in addition to their nurses' training. The population of Hyde Park is 22,664. There are 13 doctors, of whom 11 call upon our services. A local committee of representative Hyde Park people are active in raising money for the maintenance of the work and are invaluable in the practical help they give the nurses in their daily work.

The general idea of administering the nursing service from the center is that known as generalized public health nursing, which means that so far as possible, only one nurse shall visit any home for the purpose of performing any health function whatever.

Fig. 3. The public health nurse finds the mother as eager to learn as if this were her first baby.

No child hygiene work had previously been attempted in Hyde Park. In Boston this branch of public health work is done by a separate society known as the Baby Hygiene Association.

The Instructive District Nursing Association obtained the interest and cooperation of this association and is establishing a well baby clinic at Hyde Park Center. All the home visiting is done, not only by a separate staff of baby nurses, but by the public health nurses already visiting in that particular locality. Both the medical director and superintendent of nurses of the Baby Hygiene Association have general supervision of the clinic.

During the six months, January 1 to June 30, 1917, 47 cases received prenatal care, and 89 confinements were cared for. Twenty-three conferences were held during the twenty-six weeks; the total attendance at the conferences (registered babies) was 347. The average attendance at the conferences was 15; the average age at the time of admission was 15 weeks.

Registered babies received, in all, 1,107 visits. There have been no deaths, and no baby has been seriously ill, although two have had bronchitis and one pyelitis.

All milk modifications are prepared in the homes, and all milk is delivered at the home. The mothers enjoy the home modification, and as a rule are very teachable.

The nurses do bedside nursing, prenatal nursing, well baby nursing, and factory nursing. A tuberculosis clinic is held in the center under the direction of the Boston Consumptives' Hospital, but the nursing from this clinic is at present carried on, not by Instructive District Nursing Association nurses, but by a Boston Consumptives' Hospital nurse, who has desk room in the center. To complete the plan, both this nurse and also the Hyde Park School nurse should turn over their home visiting to the nurses of the Hyde Park Center.

One great advantage of this method is that all the people of the community soon learn to connect the idea of health and health visitors with the center and to call freely upon the supervisor, who keeps regular office hours three times a day for advice and help. No one is so quick to refer a patient in need of medical care to a doctor as a good nurse, and the doctors of Hyde Park find the center a great convenience in their practice. In face of the shortage of nurses and doctors because of the war, this economical method of administration of health work deserves attention.

The following true story is typical of the relation established by a good public health nurse and is so far descriptive of the many functions of these workers that I am quoting it here:

> We made a visit on a dull winter afternoon in a tenement of four rooms. There was a kitchen, dreary and dirty; two boxes of bedrooms, ventilated and lighted, if we may use those words, only by a door with a few panes of glass in it, opening from each into the kitchen; the fourth room unused because of big holes in the floor opening into the cellar.
>
> We found a woman, old beyond her years, below par mentally, and apparently addicted to the use of alcohol, holding a child, pale and emaciated—two years old and not yet able to walk. Two of the other four children were at home with colds, healthier looking, but dirty. Further acquaintance completed the picture of the family by showing the father to be an able-bodied man, good-natured with his family, mentally superior to his wife, but intemperate, making small wages. Inquiry at the Confidential Exchange brought out the fact that the family had been known to the Associated Charities and to the Society for the Prevention of Cruelty to Children because of the intemperance of the parents had led to neglect of the chil-

dren. It is not strange, therefore, that when this family was brought to the case committee its members, socially trained or not, almost unanimously voted it a hopeless family and felt that the one solution was to break it up. What hope was there for such a family in those surroundings? What possible chance for the coming baby? Only the nurse and priest had hopes; they asked for another trial. A brief sketch of the outcome of that trial justifies their faith. The doctor on the committee gave medical attention to the mother and the sickly two-year-old. The board of health aided by condemning the tenement and telling the family to move. This they did between visits of the nurse and were lost for a while. The neighbors said they had moved "one or two streets, over near the saloon on the corner"—very indefinite information for that locality. However, one of the children saw the nurse on the street and ran to greet her, and connection was restored.

Fig. 4. The nurses have added to their other work the after-care of infantile paralysis.

The new tenement was an improvement and was cleaner. The sisters in her church gave Mrs. C. a picture or two, which, with curtains for the windows, quite stimulated her to tidiness and to pride in her improved condition. Shortly after this she gave birth to a still-born child and recovered normally. Things on the whole were a little better, not much, because, while the mother was doing better, the father was out of work most of the time, and drinking. The one great thing that did count was that the nurse was considered now a real friend, and so had sufficient influence to take decided steps with the father. She found him at home one morning very intoxicated, very genial, and very proud to introduce "my wife and my five children."

"If," said the nurse, "you are so proud of your wife and five children, why not brace up, take the pledge, and go to work for them?"

After some effort to postpone it until he had had one more drink, he decided to take the pledge at once if the nurse would go with him, or at least walk behind him. He felt he was in no condition for her to walk with him. So the procession of two moved up the street, C. ahead, waving his cap in encouragement to the nurse behind as each saloon was victoriously passed. That was nearly a year ago. C. has kept the pledge, even though he is now a longshoreman, and this kind of work conduces to hard drinking. He has provided for his family to the best of his ability, his wife has kept the home clean, and together they are doing their best for the children.

He has regained some pride in his manhood and has refused to receive aid from relief-giving agencies, even when work has been scarcest. At the time when their need was greatest the wife went out scrubbing, but only until her husband got work.

At Thanksgiving the landlord, who had watched their upward struggle, returned a dollar and a half of the four dollars C. paid him toward the rent bill. Mr. C. gave his wife fifty cents and kept the dollar. A little basket from the Fruit and Flower Mission found its way there on Thanksgiving Day. There is never more in these baskets than a few delicacies beautifully arranged, but the fact that it had come had a regenerating effect on Mr. C.

"Where did you get that, Mary?" he asked. "Well, if you've got that I'll have to give you this, too," he added, after a minute, and pulled out the dollar bill he had meant to save because "it makes a man feel good to have something in his pocket." "Take that and buy a chicken to go with the things."

Three years later, the last report from this family shows that they are living in a very pleasant apartment of five rooms. Mr. C. is going to night school and so is his son, Johnnie, who, although 16 years old, had never learned to read or write. Mr. C. has joined the Home Guard.

The Place of a Psychiatric Clinic in a Prison System

Dr. Bernard E. Glueck, director of the psychiatric clinic at Sing Sing Prison, in a recent number of the *New York Medical Journal*, writes that there was no well-defined precedent to follow in starting the Sing Sing clinic; the problems were met according to individual reaction and not according to rules. The functions of the clinic are therapeutic and reformative so far as the inmates are concerned, and educational so far as outsiders are concerned. The aim at Sing Sing is to keep alive the prisoner's initiative and self-expression; men come to the clinic voluntarily in states of depression. No cases of mental disorder have developed within the prison within the past four and a half months. Although crime is a problem of behavior, and information regarding it is to be sought in observation of the individual who has behaved in a criminal manner, prisons have not yet been made available as clinical material for teaching. The psychiatric clinic is also an agency for propaganda and education in a broader sense. Since August, 1916, for instance, the clinic has furnished to the parole board reports of examinations of the men about to be paroled, and these reports have been consulted before the paroles are issued. Moreover, the psychiatric clinic has had an influence as a constructive and reformative agency. The psychiatric examinations have been found of great advantage in helping the man to reform.

A large percentage of the prisoners were found physically or mentally defective. Seventy-four percent of fifty consecutive admissions were found suffering from one or more of the following disabilities: syphilis, mental defect, alcoholic deterioration, morphine deterioration, and insanity.

A UNIQUE ATTEMPT TO EXPRESS MEDICAL SERVICE WITHOUT CHARITY

Under a Gift by Mr. E. W. Scripps, Physicians of San Diego Have Organized a Diagnostic Clinic With Some Promising Features—Some of the Details

By ROBERT POLLOCK, M. D., San Diego, Cal.

It has been observed by many and commented upon by not a few that the non-paying classes in any general hospital get distinctively better diagnosis and usually better treatment than those a little higher in the social scale. The latter insist on paying their way, although forced by the limitations of their income and a lack of flexibility in our medical service to stop far short of what their cases actually require.

It is an ever-present question how we can serve these classes more satisfactorily. If, through hospital or clinic, we furnish them adequate service at a price within their reach, we are likely to do so at the cost of underpaying the physicians who give the service, thus simply expressing another kind of charity.

It may be that, in time, we shall all pay for such service by direct taxation, but attempts in this direction would at present draw considerable opposition. A problem demanding our best thought is how to give to the family of the workingman and the small-salaried classes comprehensive diagnosis and adequate treatment at a cost commensurate with their income, and still keep the endeavor free from charity by paying the physician a fair price for his services.

An attempt to solve this problem has been started in San Diego by Mr. E. W. Scripps, a newspaper owner and philanthropist of nation-wide reputation. While it was his hope eventually to see such intelligent expression of this idea on the part of the medical profession as to make it a self-supporting movement, he was willing at the start to meet annually such deficits as might be unavoidable. His conception of service included a clinic where diagnosis of intricate cases could be made by a staff of specialists, and a hospital in which treatment of all kinds could be carried out. This hospital would receive patients from any reputable physician provided the cases belonged to the social classes he elected to serve.

The initial unit in the expression of his ideal took the form of the San Diego Diagnostic Group Clinic on the John P. Scripps Memorial Foundation. Property owned by him at the time, a well-built residence in a central location, was remodeled and equipped to suit the requirements of the clinic. The ground floor, consisting of five large rooms, comprises the administration offices, two large, well-equipped examining rooms, and a consultation room, where the members of the staff meet daily to discuss the results of their examinations. The second floor contains accommodation for six patients and for the three trained nurses who serve the patients, take histories, and aid in many ways in the examination of the patients. The third floor is occupied by the butler, who, with his wife, prepares and serves the meals and takes care of the house and grounds.

The examining rooms are equipped with every modern apparatus that a first-class hospital would consider necessary to complete, accurate diagnosis. At present most of the laboratory work and all of the x-ray work is done at their laboratories by the men representing these departments. The accompanying illustrations suggest in some measure the arrangement and equipment of the building, as well as emphasize what may be done temporarily without the erection of an expensive hospital plant.

Fig. 1. San Diego Group Clinic building of the E. W. Scripps Memorial Foundation, given by Mr. E. W. Scripps.

No attempt is made to reach a diagnosis by intuition. Each patient—and the cases are all problem cases—has his history carefully taken and is then assigned a room to be used during his stay in the clinic, which is until every member of the staff has carefully examined him. Each recognized department of medicine, including dentistry, biochemistry and radiography, is represented on the examining group, which consists of seventeen specialists. The word "specialist" is here used in its broadest sense to include any physician who has demonstrated his fitness to examine and give an expert opinion on a special

field. An effort is made to include on the staff all men eligible under this construction, with a result that, of a total membership of 120 in the county medical society, 60 physicians, or a total of 50 percent, are represented on the staff. These serve in relay groups for a month at a time.

Each member of the group, on completing the examination of his particular field, dictates his findings to the nurse-stenographer, who casts them into a report for use at the general discussion. The various members of the group on service are served lunch daily in the clinic dining

Fig. 2. Main examining room of the San Diego Diagnostic Group Clinic.

room, and at its conclusion spend an hour discussing the cases who examinations have been completed. With one member acting as chairman for the month, each in turn refers to his findings and expresses his opinion as to their bearing on the complaint of the patient. When a composite diagnosis has been satisfactorily reached, the chairman dictates it in proper form to the stenographer, who mails a copy to the physician referring the case to the clinic. A suggestive outline of treatment is included when deemed desirable. No cases are taken for diagnosis unless referred to the clinic by a physician. The referring physician is always invited to be present at the discussion of his case. The cases while in the clinic are looked upon as being still in charge of the referring physician, and his interests are carefully guarded at all times.

A lump sum is charged the patient for the diagnosis, which sum covers the expense of his stay in the hospital. Thus, while it is in the interest of economy to complete the diagnosis as expeditiously as possible, when the patient's stay is necessarily prolonged he is not made to feel that his bill is being increased. The amount of the fee is based on the monthly income of the patient and is required invariably in advance. This fee ranges from $10 to $25 per patient, and at present the cost to the clinic of making a diagnosis is much in excess of the fee paid by the patient.

In conclusion, I would call attention to a few of the distinctive features of this movement:

It is planned entirely in the interests of the man of small income.

It is expected that only cases will be referred to the clinic which have already proven themselves troublesome diagnostic problems.

Previous diagnoses and opinions of the patient or his friends are not allowed to bias the examiner, as each specialist examines and reports only on the field of diagnosis assigned him. It is only in the general assembling of all the data that the composite diagnosis is thrown into prominence.

There is little possibility for "snap" diagnoses.

Many defects of the individual are brought to light, which, while not bearing directly on his present complaint, are valuable data for the patient and his physician to preserve.

Looked at purely as a precautionary measure, such a diagnostic scrutiny once a year is a valuable expression of preventive medicine.

The physicians of our staff are strongly enthusiastic regarding the cultural value to themselves of the discussions held over these cases.

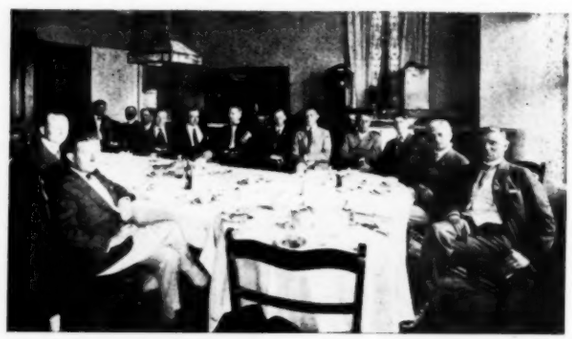

Fig. 3. Dining room, where, after luncheon, the members of the clinic spend an hour discussing the cases examined.

Where so large a percentage of the local medical profession is enjoying this cultural development, the effect upon the whole community in the way of raising the general standard of medical service is bound to be noticeable.

As the patients are asked to pay a relatively small fee, and as the overhead expense until the building of a hospital must be entirely borne by the clinic, a deficit seems inevitable; and the staff for the present has elected to serve without remuneration. Its members, however, feel amply repaid by the cultural effects above referred to, as well as by the privilege afforded of having their problem cases thoroughly diagnosed for a modest fee and returned to them for treatment.

STANDARDIZATION OF HOSPITALS—CLASS IV, SMALL SEMIPUBLIC HOSPITALS

Semipublic Hospitals of Fifty to One Hundred Beds the Most Numerous Class in This Country—Advantages and Drawbacks—Number of Nurses Desirable

By JOHN A. HORNSBY, M. D., Chicago, in Collaboration with MISS MARY WHEELER, Principal of the Illinois Training School, Chicago; DR. SOLOMON STROUSE, Former Pathologist in and now Member of the Medical Staff, Michael Reese Hospital, Chicago; MISS RENA S. ECKMAN, Former Dietitian, Massachusetts General Hospital, now of Teachers College, Columbia University, New York; DR. J. T. CASE, Roentgenologist, Battle Creek, Mich.; DR. EDWARD S. BLAINE, Roentgenologist, Cook County Hospital, Chicago; MR. E. C. LARSON, Former Accountant, now Assistant Superintendent, Michael Reese Hospital, Chicago; MR. MICHAEL M. DAVIS, Jr., Director, Boston Dispensary, Boston, Mass.

THIS month we are to discuss one of the most important classes of hospitals in this country—Class IV under our schedule, semipublic hospitals of 50 to 100 beds.

There are probably more hospitals under this class in this country than in any other class that we have noted in our schedule, and but for one or two rather important differences we should increase this class numerically by the addition of small public hospitals of like size. Because of the necessity resting on these public hospitals to accept free patients to be paid for out of general taxation, we shall have to discuss this class at another time; most of these public hospitals do not accept pay patients at all, and the controlling fund in the management of these public hospitals is usually some representative of the tax-paying public. So we shall have to confine our discussion to the semipublic institutions controlled usually by a board of trustees selected by some hospital association or group of financial supporters, and provided with funds by annual subscriptions, by personal gifts and bequests, by funds from endowments, and by earnings from paying patients.

These small semipublic hospitals are usually better institutions than public general hospitals of like size because they are untrammeled by politics, usually free from any form of favoritism, and are conducted usually by wholly disinterested people who hold office usually for long periods of time, and who come eventually to have very well-rounded knowledge of hospital work. Here and there we are bound to find a trustee or staff member who will use the hospital for his own selfish purposes, but the baneful influence of this one-man control, and that a self-interested control, is rarely very serious, and there is far less of it nowadays than there formerly was, because the public generally is coming to appreciate its hospitals, and the intelligent members of the community can usually put a stop to any hampering influences by their control of the purse strings.

The schedule for the marking of this class of hospitals does not differ from that which we are using throughout, but the requirements under the various department heads are different, and we shall now attempt to outline some of the things in each department that we have a right to expect in a hospital of this class.

THE MEDICAL STAFF

While the amount of material, that is, the number of patients, is smaller in this than in hospitals of larger size, the patients themselves are quite as important and, being fewer in number, can perhaps be given a little more individual attention. If the medical staff is composed of the right sort of men, and if these men apply themselves diligently to the hospital work, and if they keep abreast of the times and the literature of their profession in the several departments, the patient in this class of a hospital has a right to expect just as good care as he would get in a large metropolitan institution, even a teaching hospital, with one slight difference, viz., that the men in this small hospital will probably not have had quite the same experience and will usually be not quite so well read and so skilled in their work as men in larger institutions, especially men who have been kept up to their best by the necessities of teaching requirements—men who have had to keep themselves on keen edge by the stimulus of the student body. This handicap in these community hospitals is also passing away with the new order of the present hospital era because its staff members are getting out of the doldrums of their own institutions more and more and are attending conventions, visiting hospitals and clinics, and in other ways keeping their minds bright and fresh and up to date by association with their fellows in the profession. This picture rather implies a great promise for patients in this class of hospitals.

There is no reason why the staff of this hospital should not be organized in the same way as in hospitals we discussed last month—that is, those of the larger size in the same group, but with perhaps less elaboration. There can easily be a surgical service with a sufficient number of men to perform the surgical work, a chief or active head of the surgical staff and associates, whose office

necessitates his paying attention to the administrative things that have a bearing upon the welfare of surgical patients. It is his duty to see that the operating room technic is kept up; that the sterilization of materials is efficient; that the record-keeping is properly done; that the nursing is what it should be; and that the surgical equipment and facilities are the best that can be afforded.

The same sort of organization can go through the other departments, and the specialties can be represented quite as effectively as in a very much larger hospital.

If the men on the medical staff are chosen for their ability, energy, and enthusiasm, and if there are no drones and no "has-been's," even though these latter be men of wealth and large practice and wide influence, then the marking for the staff should be high, and if the staff is well organized so that efficient team-work can be done, and so that cases can be promptly and effectively referred from one service to another for examination and diagnosis, then these points, too, should be given expression in the marking; and in proportion as these requirements are not met by the staff, then the marking must be low.

The House Staff.—It is becoming extremely difficult for hospitals of this class to secure sufficient interns from high-class schools—and almost impossible unless the hospital has the reputation of being among the best in its class. It has been figured out pretty conclusively that an intern cannot give efficient service under the direction of the attending physicians to more than 25 patients even in a large ward; and with the usual conditions operating in a 50- or 100-bed hospital, with many attending physicians whose requirements and the methods vary greatly, good intern service cannot be performed by one man for more than 12 or 15 patients. A 50-bed hospital should have at least three interns, and four will be much better, especially if the interns are required to help with the routine laboratory work, the x-ray work, and the giving of anesthetics.

If a visiting staff is lackadaisical and indifferent, it is certain that the intern staff and the intern work will be inefficient. In other words, the character of the intern service of the hospital will be a reflection of the visiting staff, and we have indicated this by leaving a marking of only 5 percent for the interns as against 20 percent for the visiting staff.

The Nursing Service.—Tentatively and rather against Miss Wheeler's wishes, we are continuing to treat the nursing service as a part of the medical work of the hospital and to count the nursing staff as a part of the medical staff. Just here we might add that it is the intention of the collaborators in this series to go along discussing these various classes of hospital and the features of their standardization, accumulating information and building up a constructive fabric, calling upon those in active hospital work to help out as their own several classes of hospitals are reached, so that at the end we may have a fund available, out of which to set up a pretty satisfactory structure.

Whatever may be the conditions of the nursing service in many classes of our hospitals, we are upon pretty firm ground in discussing the nursing in these 50- to 100-bed semipublic or community hospitals. Since these are general hospitals with well-rounded service in most departments, all these hospitals can maintain training schools and should do so, and those hospitals that are of the right sort, with visiting medical staffs of the right kind, ought to have no difficulty in securing material for their training schools, usually from the clientele and patrons of the doctors. It is certain that parents would rather have their daughters complete their schooling and add to their accomplishments a profession which may become the basis of valuable careers, than have them go away from home into an environment not always of the best, and where they may be surrounded by an uncongenial, unaccustomed, and not very attractive atmosphere. Not always are these hospitals able to secure college women for their training schools, but almost always they will be able to secure young women of good breeding and good, wholesome home training, and, while this kind of material may not be the best out of which to mold training-school teachers, it is certainly excellent material out of which to make nurses who are actually to nurse.

In many of these hospitals the superintendent of the institution is also principal of the training school. In some cases her assistant acts as principal of the training school; in a good many of them the principal of the training school is an entirely separate entity and has practical charge of the care of patients, directly under the doctors. But these are minor matters and the personal element settles them in most cases. It is not quite so important whether the principal of the training school is answerable to the superintendent or to a training-school committee of the board of trustees as it is that she should know how to conduct her school and how to train her pupils to take care of patients and in the theoretical or book part of her professional service. It is quite essential that she shall know how to handle young women and to handle her own graduate assistants, and whatever graduate nurses it may be necessary to call in for special or private work. All this means discipline of a training school.

The reason that in some cases the superintendent retains the position of principal of the training school and puts in her own assistant as acting principal is that the superintendent feels that in that way she can center the responsibility in herself and thus be enabled all the better to maintain discipline and prescribe the necessary team-work with other branches of the institution. This item of team-work is a very important one; without it the doctors will be handicapped in their care of their patients, the administrative departments of the hospital will be greatly hampered in their efforts at efficiency and economy, and altogether the hospital will be ineffective and not of that same value in the community that it ought to be.

How many nurses shall these hospitals have? Our wisest leaders in the nursing profession think there ought to be as many as one nurse to every two patients. Others, again, give excellent reasons why one nurse to every three patients is sufficient; but it may be added, as a flat proposition, that the more nurses there are, other things being equal, the better will the patients be served. Of course, there are exceptions—cases in which the nurses are not properly disciplined or are actually in each other's way. One who is attempting to mark a hospital under this scheme of standardization should differentiate between an effective, efficient, energetic, well-disciplined training school, and one that merely has a lot of young women, unorganized and working in a haphazard sort of way and often at cross purposes with each other.

We are thinking now about acute-disease hospitals, with most of the general services and with only the normal number of convalescents and ambulatory patients that an acute-disease hospital would have. Our nursing requirements must be predicated on these conditions, and we must assume also that there are a sufficient number of domestics and orderlies to relieve the pupil as well as the graduate nurses of all menial occupations, because it is no part of a pupil nurse's business to scrub the floors or clean the rooms.

One other point: we occasionally find pupil nurses doing all the "special" service in the hospital, and sometimes we even find probationers and first-year pupils assigned to private cases in private rooms, even where the patients are extremely sick and require what we might call technical nursing. A hospital that does this sort of thing should be marked down very low. Of course, the reason it is done is to bring in that extra income to the institution. The hospital charges $15 or $20 per week for "special nursing," pays the pupil nothing, and the hospital pockets the money. It is a fine training for an advanced pupil nurse to get private case work, and in a good hospital the private nursing of senior or even intermediate class pupils is to be desired over that of graduates, because often graduates brought into a hospital happen not to be well trained or to have been out of training for so long that many new methods have been instituted since their time. These graduate nurses resent the interference of training-school heads, whereas, in the case of an intermediate or senior pupil nurse, the work is done under trained direction and under the discipline of the institution. It is wrong to put a probationer or a first-year student away off to herself with the responsibility of the care of any patient, private or free, and where this is done the training school should be given a very low mark.

All too frequently the curriculum in these community hospitals is about the only thing in the nurse training except hard bedside work that the pupil gets; in other words, there is a curriculum, but it is not carried out, and even when an attempt is made to live up to it it is futile and inefficient because medical staff members and interns who are unable to teach form the faculty and their instruction is often too poor to be dignified as teaching. A curriculum does not make a training-school course; it is what is done under that curriculum.

The living conditions of pupil nurses constitute a very important factor in the training school. If the pupils are huddled together in dormitories and have no individual privacy the morale will be bad, and unless they have the common living arrangements usual for young women in their class of society they will miss very much of the atmosphere that they will find when they go out into private nursing practice and they will have become unaccustomed to the influence and the ways of patients with whom they come in contact and will not give a good nursing service; if they are not taught home economics, cooking, and the hospital dietary they will also fall short when they go out into practice and will not be able to see that the orders of the physicians are properly carried out.

All these items should be taken into account in any attempt to standardize the training school in this class of hospitals.

LABORATORIES

We cannot expect the same elaboration in the laboratory arrangements of a 50- to 100-bed hospital that we would have a right to expect in those of larger size and broader service; but we have a right to expect that any hospital which has its doors open as a place in which to care for the sick shall be able to perform the necessary laboratory work to give the physician help in diagnosis and

treatment, according to the demands of modern medicine. It is assumed that there are good chemical reagents, that there are properly devised and properly working incubators, refrigerators gauged to preserve antitoxins and serums, that the hospital shall be able, in some way, to make autogenous vaccines and to administer these properly. We should expect that blood pressures, Widal tests and tuberculin tests can be made, that spinal puncture can be done, that an antimeningitis serum can be administered when required, and by someone properly trained to do the work. In pathology, such a hospital ought to be able to make tissue diagnosis, in at least the plain and obvious cases; there will usually be time for tissues and solids to be sent away for confirmatory diagnosis in the obscure cases.

There should be proper direction of the laboratories; that is, there should be someone as director who is qualified to do the work above outlined and who is likewise qualified to supervise the routine work that may be done by interns and associate members of the medical staff. It may be necessary to accept part-time service of such a man, and if the director be qualified it will not do to demerit the hospital because he does not give all his time to the institution. Such a director would require a considerable salary for his whole time, usually in excess of what a hospital in this class could afford to pay, but almost everywhere in this country today the part-time service of such a man is available, in any event, in localities that can support and use a hospital of this size.

The laboratory department of the hospital should be conducted under some well-planned scheme of organization. There should be definite technic for the work in all its branches, methods for collecting specimens through the hospital and for sending them to the laboratory with proper checks attached, and carbons should be used in order that the laboratory may keep a permanent account of the work it does and that there may be copies of all reports for filing with the records of individual cases.

The laboratories should permeate every part of the hospital with their scientific atmosphere, and there should be ample evidence in all parts of the institution, especially in the medical staff, that the laboratories are a definite influence and are actually employed in the diagnosis and treatment of patients. Where such an atmosphere is present some research work will be done and interesting cases will be prepared for publication and issued from the hospital in some published form. All these things should be taken into account in the marking of the hospital.

THE X-RAY DEPARTMENT

For the benefit of trustees and those supporters of the hospital who are interested to know that their institution is properly equipped and has proper facilities for doing modern medical and surgical work, the following list of x-ray equipment is given, with the suggestion that there are in nearly every community men and women of means who, if properly approached, will be willing to make up the deficiencies in this department by contributing the necessary funds. There is really no excuse for any hospital in this class not having adequate facilities and equipment, not only to make pictures of the long bones, but also to make plates of soft tissues, do good fluoroscopic work, and provide adequate treatment in keeping with the demands of modern therapy.

1 Model C transformer, 220-volt, 60-cycle, A. C	$ 600.00
1 No. 1 radiographic stereoscopic table	230.00
1 auxiliary tunnel and 2 plate changes	25.00
1 cord reel post and 3 cord reels for horizontal fluoroscopy	17.25
1 No. 3 radiographic stereoscopic and fluoroscopic stand	215.00
1 No. 3 fluoroscopic arm, with counterweights	22.00
1 No. 3 fluoroscopic adjustable diaphragm shutter	25.00
1 10 by 12 fluoroscopic screen mounted in protection frame	57.50
1 foot switch	27.00
1 stereoscope	98.50
1 x-ray plate chest	16.00
1 11 by 14 intensifying screen and metal cassette	47.00
1 lead rubber protection apron	12.00
1 lead rubber protection gloves	12.00
1 x-ray tube hanger, 5 tubes	4.50
1 tube hood cloth (for excluding tube light in fluoroscopic work)	3.75
1 x-ray protection screen	39.00
	$1,451.50

COOLIDGE TUBE EQUIPMENT

1 Coolidge tube transformer	$ 35.00
1 Coolidge tube regulator	35.00
1 Coolidge tube meter	35.00
1 Coolidge No. 6 stand for regulator	11.50
1 Coolidge insulated shelf for transformer	3.50
1 fine focus Coolidge tube	125.00
1 broad focus Coolidge tube	125.00
1 medium focus hydrogen tube	75.00
1 Coolidge cathode terminal	1.25
	$446.25

OVERHEAD CONTROL SYSTEM

1 set wall insulators, 4-arm	$13.00
200 feet trolley cord wire	6.00
2 trolley cord reels	6.50
2 Coolidge trolley cord reels	8.50
	$34.00

DARK-ROOM OUTFIT FOR OUTFIT NO. 2

3 8 by 10 developing trays	$ 3.75
3 11 by 14 developing trays	7.50
3 15 by 17 developing trays	12.00
1 ruby light	6.75
1 dark-room apron	1.00
1 16-ounce graduate	.50
1 drying rack	1.25
1 midget shadow box	6.00
1 interval timer	3.25
2 32-ounce glass-stoppered bottles	1.50
24 packages developer	6.00
25 pounds C. P. hypo	1.50
	$51.00

Plates, films, as selected.

Total of equipment absolutely necessary for operation	$1,531.75
Total of complete equipment	1,982.75

This includes equipment that greatly assists in operation of the outfit, but can be dispensed with at first and added later when desired.

THE DIETARY DEPARTMENT

There is an immense amount of nonsense practiced in the smaller hospitals of the country in the dietary department. "Diet lists," the efficacy of which has been disproved for years, are still in use, and in many of these hospitals each visiting physician has his own favorite lists, mostly predicated on principles that are no longer recognized

by physiological chemists and food physiologists. Frequently these lists are so sacred as to be veritable fetishes in the institution. Modern physiology, in the light of the present knowledge of metabolism and its laws, declares that each case is a special study in itself and should be treated without reference to printed or published lists. No two individuals respond in the same way to any course of special feeding, and modern clinicians recognize today that they must study their cases with the aid of the laboratories, and change their diets, articles of food, and amounts and frequency of feeding in step with the response of the patient. This means that the dietetic department of even a small hospital is one of the scientific agencies for the treatment of patients, and a cook, however efficient in the preparation and service of ordinary foods he or she may be, is wholly inefficient to conduct the department of special feeding, even in the class of hospitals that we now have under discussion.

Four or five years ago there were only a few trained dietitians in the country, and one might count on the fingers of one hand the women in the United States who could be consulted by clinicians with the hope that some effective therapeutic methods of treatment might result; today there are many of these women, and the number is growing rapidly. A few well-chosen leaders are inspiring the rest, and the time is almost here when every hospital in this class may be expected to have in its employ a trained dietitian who would be in reality a part of the medical service of the institution.

There should be system in the dietary department. Forms should be used in every case that requires special feeding, and the proper use of these forms should keep the clinician definitely informed as to what his patient is actually getting, when, how much, and its chemical constituents. These charts, properly kept and taken in comparison with the laboratory findings from time to time, ought to give the clinicians a check on their work that would render their treatment most profitable to the patient. Unless such records are used and used in a routine way, the hospital should be marked down. And, even though there be a good dietary department, if the physicians practicing in the hospital do not make proper use of it, then the institution should be marked down for that department and kept down until the physicians recognize the demands of modern medicine in their hospital practice.

PHARMACY

There should be no substitutions of "something just as good" by the pharmacy in any hospital. When a doctor prescribes a medicine that is too expensive for the institution to pay, the same arrangement should be made for its purchase in each individual case. A doctor who insists upon the routine prescribing of expensive medicines may be reasoned with, but substitutes are not permissible under any circumstances.

Nor is it permissible to keep medicines in a hospital in the wholesale way of a former day, using numbers for various routine prescriptions. We are not employing "shotgun prescriptions" any longer, and, as a rule, doctors are using the simplest forms of prescription, giving only the medicines that are actually called for; ergo, honesty in the pharmacy is one of the first requisites.

As an economy proposition the pharmacist ought to be well informed as to the source, processes of manufacture, and the standardized strength of various pharmaceuticals; whether he shall make his fluidextracts and tinctures is not quite so important, but if he does make them they should be made out of carefully selected herbs and original sources, with some check on strength and efficiency.

The modern pharmacy is not as important as it was a while ago, and its place in the cure and care of patients is becoming less important as time goes on and our knowledge of the cause, course, and cure of disease increases.

There should be an economical side to the pharmacy; large quantities of drugs should be bought with a view to their economical use. Flaxseed meal can easily deteriorate, but it is expensive to buy in small quantities, so there is a happy medium; chloroform, ether, alcohol, glycerin, and many other officinal drugs should be bought and stored with a view to their keeping qualities as well as to the economy in first cost.

Above all else, there should be a definite technic as to the distribution of drugs to the wards and hospital units, and it is equally important that medicine cabinets on the floors should be so arranged that economy and efficiency can be practiced. In many of these smaller hospitals there is no system about the keeping of ward medicine cabinets, and it has happened that half a dozen bottles of precisely the same drug are in stock and a new bottle ordered whenever that drug is prescribed. This is due to the fact that the cabinets are stuck away in some dark place and so arranged that bottles stand in front of each other where nurses cannot see them.

In some hospitals, also, probationers and first-year nurses are given charge of the medicine cases, which is a pernicious practice, with the result of constantly recurring stories in the news-

papers about some patient dying because the wrong medicine was given.

A failure to recognize all these essentials in the pharmacy department of this class of hospitals should cause a low mark in any attempt at standardization.

DISPENSARY, OUT-PATIENT DEPARTMENT, AND SOCIAL SERVICE

Mr. Davis feels that the social service department is something entirely different from the dispensary and out-patient service; and it is only for the purpose of tentative discussion we still retain this relationship in considering these departments together.

There can be no hard-and-fast rule about the size or elaborateness of service in the out-patient and dispensary departments of the class of hospitals we are now discussing. Almost everything will depend on conditions in individual cases. If there are few poor people in the community and little need of charity service, the dispensary and out-patient department can be correspondingly small. But in every community there are the people of most modest means who would not accept charity and who yet cannot afford to pay for the private services of a physician over a long period of convalescence or treatment. It is becoming rather a frequent practice in hospital service to permit attending physicians to bring this class of patients into an out-patient department of the hospital, where they may be given adequate attention at a lower cost than would be possible in the physician's private office. These so-called pay clinics seem to be acceptable, and the hospital is not to be marked down because of such dispensary service.

Nor is it outside the legitimate service of a hospital to have patients, especially surgical patients, returned to an out-patient department for convalescent dressings; indeed, this is the most economical and satisfactory way, in many of these cases, to continue treatment without interfering with the regular hospital activities. If there be an out-patient department, it should be adequately conducted, and it is not sufficient merely to accept patients in this department, treat them, and let them go their way without any check upon their future movements. In a great many hospitals minor operations will be performed, dressings put on, and patients allowed to depart and left to their own devices as to whether they return or not. Much harm has come out of this slipshod practice. It is absolutely necessary, if an out-patient department is to be maintained, that there be some follow-up system, some visiting and home nursing done, and a failure to do this is to be condemned.

Nor is it sufficient that there be an examination in the out-patient department and an order given for medicine without some serious attempt to make an accurate diagnosis and the prescribing of adequate and promising treatment. This means that there must be available for the service of the out-patient department an x-ray service and a clinical laboratory capable of doing any kind of work that might possibly be called for even in the hospital itself. Often autogenous vaccines can be utilized to advantage for out-patients, and certainly it is frequently necessary to identify microorganisms associated with disease, and an out-patient is quite as much entitled to this efficient service as the patient in bed in the hospital. In other words, the old days of the hit-or-miss dispensary practice are gone, and when a hospital decides to maintain an out-patient service it obligates itself by inference to do the work efficiently and in step with the demands of modern medicine.

It is believed that these hints will enable a surveyor to mark this department of this class of hospitals in a helpful way.

MEDICAL RECORDS AND ACCOUNTING

As we have intimated in discussing other classes, record-keeping and accounting in the modern hospital are indissolubly related, and both items are in such process of evolution at the present time that no hard-and-fast rules can be laid down by which the system of one hospital may be condemned and that of another accepted. But there are some fundamental principles at issue which can be taken into account and upon which a hospital may be tentatively marked until such time as we have arrived at some definite standards of accounting and some definite standards of record-keeping.

Any system of hospital accounting must be simple and yet capable of furnishing information as to what the institution is doing, how, and at what expense. In any system of accounting the superintendent should be able to ascertain at a moment's notice just precisely what each department of his institution is doing, with details as to income and expenditure. There must be in even the simplest system a detailed account kept on both sides of the ledger of every department and of every service; for instance, it is not sufficient that we keep a food account, and let it go at that. We must also keep, for instance, a meat account; not only a meat account, but a pork account and a beef account, and so on down the line. These accounts should be so kept that at any time the superintendent may call for any detail and have it.

Special departmental account should be in sufficient detail so that the superintendent may have

the information at any moment as to whether the department is making or losing money, and if so, how much. He will obviously be in position to evaluate the services of the departments aside from the wholly financial transactions.

As yet there are no standardized methods by which the per capita cost of the institution is to be arrived at; this is one of the fundamental weaknesses in our present chaotic hospital accounting systems. Some hospitals, by their bookkeeping, count every expense before doing the arithmetic to arrive at the per capita distribution of costs, and these hospitals have a high per capita cost. Other institutions soothe themselves into a happy frame of mind about their per capita costs by ignoring many items of everyday expenditure and do not count them when figuring on the per capita; these hospitals show a very low per capita cost, and by those who are uninformed get credit for a wise and judicious administration, when precisely the reverse may be true. The first decisive step in the standardization of hospital accounting is to come in the form of an agreement among the hospital people as to just what shall be included in making up the per capita cost, and obviously the answer is to count every conceivable expense, direct and indirect; when that day comes we shall have some figures for comparison that will do more for the efficiency of hospitals than any other one thing.

In the record-keeping there are two sides just as there are in accounting; one of these sides, and obviously the more important, is that concerned in the history of patients, their histories leading up to the diseases for which they are in the hospital, and the stories of their cases in the hospital itself. The other side has to do with the financial transactions with patients, and this feature is intimately interwoven with the bookkeeping and financial accounting of the hospital; it concerns the distribution of patients into wards and rooms and the amount they pay in special charges that may be assessed against them. It may be urged here, as we have urged so many times, that hospital administration will be far easier, the relations between institutions and their patients will be pleasanter, and the care of patients will be more efficient, when we have discarded special charges of all sorts in the hospital and fixed a flat hospital rate per bed or per ward or per room for patients, assuming that once a patient is in bed in the hospital he shall have, under the terms of his admission anything that his doctor may order in his interest.

In marking a hospital, in the department of accounting and record-keeping, the amount of information available and the promptness with which it may be had are the two primary considerations. A bookkeeping system that requires a master bookkeeper to interpret is useless to the average hospital superintendent; a record of a patient, which, not being complete and conclusive, will not be of use in the summing up of medical literature of the institution, is also worthless. A record-keeping system that is theoretically good and wholly bad in its practical working is worse than none at all, and there is really no excuse for a hospital not keeping good medical records.

These things should give considerable help in the efforts of a surveyor to mark a hospital in these respects.

ARCHITECTURE, INCLUDING PERMANENT INSTALLATION, SUCH AS PLUMBING, STEAMFITTING, POWER PLANT, ELEVATORS, VENTILATION, VACUUM CLEANING, LAUNDRY, SEWAGE, AND GARBAGE DISPOSAL

We have allowed only 5 percent as the maximum for this department; it seems a very small percentage, but, if we think in terms of the care of patients, which is almost wholly a matter of personnel and very little a matter of architectural environment, we think 5 percent is sufficient. We would give only 1 percent of this to the floor planning of the hospital and nothing at all to the exterior and ornamentation because these have so little to do with the patient's care and cure. If the hospital is planned so that the arrangements for nursing patients are economical we should consider a good mark. The vast majority of hospitals are planned without any reference whatever to economy and efficiency in the care of patients, and contemplate only appearances, as viewed by the layman and by the architect who has no conception of hospital needs and methods. For the plan of the hospital as a whole and for the plan of the various administrative units, such as operating suite, kitchens, laundry, etc., we should allow 3 percent as the maximum. For materials used in the building and in the permanent installation we should allow 2 percent. By materials we mean the class of plumbing and plumbing fixtures, steam piping, the class of flooring, material out of which walls and windows and doors are built. We should allow 1 percent for the execution of details. Most architects are extremely careless about the details of construction. Turned cove bases often seem to be an afterthought and are put in frequently without very much reference to their relation to the walls and to floors; plinths, plinth blocks and thresholds seem often to be almost foreign bodies, stuck in at the last moment; the location of lights and lighting fixtures is too often at cross-purposes with the needs of nursing and the doctors. Often

there seems to be no system whatever about the location of lavatories and toilets; frequently we will see a toilet and lavatory for a private room built next to the corridor and without means of adequate ventilation. The piping for lavatories and toilets and for the steam heating is frequently done without any reference to a system of any kind; even after our costly experiences of recent years we find architects running on the horizontal with a lavatory drain clear across and imbedded in the concrete or under the concrete. All hospital plumbing should be devised by a system, and that system should contemplate definite areas of risers so that drains may be on the vertical and easily got at when necessary. The fetish of open plumbing run along walls is happily at an end, and we have substituted vertical risers with outlets adjacent. There may be many of these risers to accommodate a possible unsystematic arrangement of lavatories and toilets, but at any rate they can be laid out on a definite principle, and in all cases horizontal runs should be avoided.

EQUIPMENT, MEDICAL, SURGICAL, AND PHYSICAL

Of course, medical and surgical equipment is absolutely necessary to the performance of the functions of a modern hospital; it makes very little difference what the architecture of an operating suite is, its form or size, but it means everything whether its furniture and furnishings are adequate for the performance of surgical operations of all kinds. It makes every difference whether there is adequate sterilizing apparatus of the various sorts and whether that apparatus is efficient and in good order. The character of the operating tables is important and the facilities for the operations in the various surgical specialties are quite as much so. For instance, head lamps of approved pattern are necessary in brain surgery and in the deep pelvis. Efficient and conveniently arranged cautery apparatus and machinery for the various trephines and drilling operations through bony structure; hoists for putting on casts, extension apparatus for hip and thigh fractures. A hospital that has not these facilities and conveniences should be marked low. We have provided a total of 5 percent under this heading and we should allow 2 percent for what we have just outlined; and 2 percent should be allowed for surgical instruments, made-up boxes for special operations, such as venesection, spinal puncture, the preparation of the dead, etc.; and 1 percent may be allowed for the physical furniture of the hospital; that is, for beds, springs, mattresses, dressers, tables, chairs, floor covering, window shades and dressings, and the other essentials to a well-furnished hospital. It is not sufficient, for instance, that there be plenty of chairs; there must also be chairs for special purposes. Straight chairs in abundance are necessary, rockers for those who need them, Morris chairs for other classes of sitting-up patients, wheel chairs of convenient design and in good order; commodes are necessary under certain conditions and ought to be part of the furnishing of each unit.

The furnishing of the nurses' home must be included at this place. It is essential that nurses have comfortable beds and that these be kept in good order as to their springs and mattresses; it is also necessary that the home shall have adequate and properly designed tables in the nurses' rooms. The home in most hospitals is provided with a table in each room—one table for two or three nurses—and this table is usually occupied by toilet articles and books so that nurses could not make use of their table in writing or studying if they were so disposed. The rooms of the nurses should be furnished with the sort of table that hotels use, flat on top but with a secretarial drawer that pulls out, having compartments with pen, ink, paper, and a place upon which to write. There should be a shelf under the table to contain books that are not in constant use, so that the top of the table may be left for those things that are in constant use, including books.

A hospital furnished with upholstered chairs and lounges and with thick velvet carpets in patients' rooms should be marked very low down because these things are dirt-catchers and germ-gatherers and cannot possibly be cleaned effectively for each new patient.

MANAGEMENT OF THE HOSPITAL

The most important item in the management of a hospital is the superintendent, and we may easily allow 2 percent for this item. Next in importance comes the scheme of organization under the superintendent—the system by which responsibility is fixed. While the superintendent should be responsible to the board of trustees for the management in every detail, the organization should contemplate responsibility to the superintendent of all heads of departments, and for this scheme of organization allow 1 percent.

Cleanliness and order in the hospital, including training and discipline of the help, should be given a maximum of 1 percent, and the organization for handling the public, the staff, the patients, employees, and the tradespeople should have a maximum of 1 percent. Very few hospitals, even the best, are arranged for the courteous and prompt handling of outsiders. Arrangements by which the doctors can be accommodated and served while in the hospital are usually negligible; it is rare

that a doctor can be given adequate telephone service in the hospital, and in very few hospitals are there conveniences for him to see privately a prospective patient of the hospital or someone with whom he wishes to confer. Employees are regarded as a necessary evil in most hospitals. There is usually no place for them to assemble except possibly the dining room, no place where they can lay away their personal belongings, including clothing, with security, and their comfort is not a consideration. The position of the house help necessary to be kept on the premises hardly ever rises to the dignity of a hospital vocation. All these things, however, are necessary and add very greatly to the service of the hospital to its public, and often the efficiency in these several regards marks the difference between a popular and an unpopular hospital in the community.

ADDITIONAL COMMENTS ON THE SCHEME OF CLASSIFICATION

FROM REV. GEORGE F. CLOVER, SUPERINTENDENT OF ST. LUKE'S HOSPITAL, NEW YORK

I have just read with much edification and interest the article in the August number of THE MODERN HOSPITAL on standardization of hospitals. To my mind your scheme of markings for the university or teaching hospital will apply equally to the large high-class voluntary or semipublic hospital. St. Luke's is a quasi-teaching hospital, although not controlled by or closely affiliated with a medical school or university, inasmuch as we receive, by gentlemen's agreement, medical students assigned to us by Columbia University.

The hospital fulfills the standards as specified in your article in every respect, except possibly that of the dietary department. From experience I am unable to concur in your opinion that the dietitian should have the entire charge of the culinary departments. As dietitians are now trained it is to my mind better that their work should be confined to teaching nurses, the preparation of special diets, and the serving of food to patients. They have not yet been sufficiently taught along the lines of general cooking, housekeeping, and the management of servants to render practicable the government by them of the entire culinary department. Chefs and high-class domestic cooks as yet know more about the economical and appetizing preparation of food and the control of cooks and kitchen helpers than dietitians. I write emphatically on this question after many experiments in the other direction and with nearly twenty-five years' experience.

DR. THOMAS HOWELL, SUPERINTENDENT OF NEW YORK HOSPITAL

I am afraid that I have no constructive criticism to offer. It appears to me that your markings are very fair. The only thing which occurs to me is that 5 points for management is rather low when compared, for instance, with 10 points on medical records and accounting and 5 for pharmacy. A good dietetic department is useful, but I do not think it is as essential as the administration department, yet both are given the same marking.

I think possibly you could do more absolute justice to the various departments if the ratings were not confined to 5 and its multiples.

DR. HAROLD C. GOODWIN, SUPERINTENDENT OF ALBANY HOSPITAL, ALBANY, N. Y.

After reading your article entitled "Standardization of Hospitals—The University or Teaching Hospital," I am convinced that the standards for teaching hospitals which you insist upon are none too high.

In the first place, there is no reason why the organization of all typical teaching hospitals should not be the same, but in this country today we find many types of organization, some of which must be very unsatisfactory. After reading the article written by you and your collaborators, I am convinced that we are practically of the same mind regarding organization and internal work of teaching hospitals. So far as I know, the most typical exponent of a teaching hospital and most modern to date is Johns Hopkins Hospital of Baltimore. If some such hospital could be used for a standard with which to compare others, it seems to me that it might save some difficulties attending standardization, for there are so many varieties of institutions in this country.

MR. T. J. VAN DER BENT, OF McKIM, MEAD & WHITE, NEW YORK

I was very pleasantly surprised to notice in THE MODERN HOSPITAL that the matter of standardization of hospitals has at last seriously been taken up. That it has been taken up by yourself certainly gives it great promise to all interested in this very particular subject.

Without wanting to appear in print, which would take too much time in preparing "proper" papers, I wish to ask if you would, at an opportune moment, kindly have a number of matters settled—call it standardized—between the different authorities.

The subjects which need standardization and on which there is so much doubt, and so many different opinions exist that it is impossible to compromise between them, and which have troubled me and are continually troubling me, are as follows:

1. Standard minimum width of a ward—a, adults; b, children.
2. Standard minimum height—a, without forced ventilation; b, with forced ventilation.
3. The minimum and maximum distance of the bed from the wall.
4. The minimum distance between the two rows of beds in the wards—a, adults; b, children.
5. The desirable maximum of the number of beds in wards—a, general hospital adults; b, general hospital children; c, contagious diseases, adults; d, contagious diseases, children; e, baby hospital.
6. The desirable (maximum distance which nurse should walk) length of ward which should not be exceeded.
7. The most desirable location of the nurses' utility.
8. The most desirable location for patients' lavatories, patients' toilets, and patients' baths.
9. Is a passage at the side of patients' lavatories and nurses' utilities parallel with the corridor an advantage, a disadvantage, or extravagant?
10. The most desirable location for diet room, day room, and linen room.
11. In how far do balconies injure the ward in relation to light, air currents, and cross-ventilation, and what changes should be made in the dimensions of the wards to offset the injury or to overcome the disadvantages, if any?
12. Which is absolutely the better arrangement in reference to placing the beds—to have a window on each side of a bed or two beds between two intervening windows?
13. Is there such a matter as too much light to be considered? Yes or no.
14. Balconies which are at times nearly completely inclosed must considerably affect the ventilation of the ward. They must also have an influence on the width of the ward and the height. Has a decision been reached in any way as to what should be done in order not to have bad results

from the use of balconies? (Nos. 11 and 14 are practically the same subject.)

15. Data are needed as to the average percentage of uppatients—a, in surgical wards; b, in medical wards.

16. Desirable minimum distance of two parallel wards.

This seems quite a long list to hand out to you, but in reality I consider these questions the most important, and deciding the entire ward service. How important they are! I wish to tell you that during seven years of constant questioning of people who should be able to give an answer, for instance, as to Question 3, the nurses invariably give answers which differ as much as 2 feet 6 inches, and in answer to No. 4 a difference between dimensions amounting to 4 feet. I am perfectly willing to set a positive minimum and maximum to all dimensions of the foregoing list, and, if necessary, defend them against all doctors and nurses. There is, however, no reason why there should be a difference of opinion.

The distance of the bed from the wall is not guided by anything but the possibility of cleaning behind it without disturbing the patient, and this certainly does not need very much more than 6 inches. However, if the beds are placed without reference to the windows, they should be at least 2 feet 6 inches, and preferably 3 feet, from the wall, as otherwise they would come too close to the windows. These two cases are the only possibilities.

As for the distance between the rows of beds in different hospitals, I would say 6 feet is a minimum for children, and in adult hospitals, 8 feet. I cannot possibly see the necessity for 12 feet between the rows of beds.

Where there is no longer any question as to what is really desirable in the matters mentioned, other subjects in hospital building would receive closer attention.

Of course, I do not expect to receive an answer to any of the above subjects until you have reached them in proper order.

REORGANIZATION OF THE CIVILIAN HOSPITAL ON A WAR BASIS*

War Department Does Not Expect Civil Hospitals to Care for Wounded Soldiers and Sailors—Their Duty to Release Scientific Staffs for War, and to Care for Civilian Population—Orders Relating to Interns and Nurses

By WINFORD H. SMITH, Major, M. R. C., Director General of Military Relief, American Red Cross, Representing the Surgeon-General of the Army

THE title on the program upon which I am supposed to address you was not of my selection, and, in fact, I do not know who did select it. I shall not confine myself to the title in these brief remarks, but shall touch upon several phases of the development of the Medical Reserve Corps of the Army, and the effect upon the civil hospitals; the part which the hospitals have played and must continue to play; and the attitude of the Surgeon-General's Office toward the civil hospitals.

It is well recognized that many hospitals have been embarrassed by the withdrawal of a large proportion of their staffs, both visiting and resident. I wish you to understand, however, that the Surgeon-General of the army and his staff have from the first recognized the need of protecting the civil hospitals, medical schools, and the public, and every effort which could be made toward that end has been made. Mistakes have been made and repeated, but you must bear in mind that the task which the Surgeon-General's office faced was the recruiting of a medical corps of at least 20,000 physicians and surgeons, and in war the needs of the army come first. However, early in the operations, the Surgeon-General's Office, with the assistance of the Council of National Defense, tried to take such steps as would safeguard the civil hospitals and medical schools. Instructions were sent to 700 hospitals, and all medical schools calling for a reorganization of their staffs on a war basis, with a view to releasing as many men as possible for service. It was requested that the staff be divided into those who could be spared and those who were needed to man the civil hospital or school, and to indicate those who were members of the Reserve Corps. Of those who could be spared, all who were not already members of the Reserve Corps were urged to join at once. The list of those who were needed to man the civil hospitals was at once scrutinized, and every man who was a member of the Reserve Corps was placed in a special inactive file. Mistakes occurred, and many of these men were ordered out, but in every such case the error was corrected whenever possible. The greatest difficulty arose from the fact that hundreds of those who, when the list was submitted were not members of the Reserve Corps, later applied and were commissioned and ordered on active duty. This was no fault of the Surgeon-General's Office. It was not expected that men who knew that they could not accept service because they were needed in the civil hospitals and schools, would apply for and accept commissions. When this difficulty arose, a letter was drafted and sent to the hospitals and schools, requesting that no man who was not in a position to accept service should apply for a commission. I wish to assure you that throughout every effort has been made to safeguard the interests of the civil hospitals and medical schools. You who are familiar with organization, must appreciate that when an organization which had been accustomed to handle a corps of about 500 was suddenly faced with the

*Read before the American Hospital Association at its nineteenth annual session, Cleveland, September 11-14, 1917.

necessity of expansion, in restricted quarters, to handle the recruiting of a corps of 20,000, and in addition to take on the formation of a dental corps and a veterinary corps, confusion and errors were bound to occur. Had it not been that the Surgeon-General had in charge of the personnel division trained men who had a proper appreciation of your problem, who had an inexhaustible supply of patience, and who were willing to work nights and Sundays, the confusion would have been worse and you would have suffered more.

After the reorganization was accomplished and the larger machine was running fairly smoothly, then the draft took place and students and interns were taken in large numbers. Early in the spring a committee of the Council of National Defense, cooperating with the Surgeon-General's Office, tried to provide in the draft bill for the exemption of physicians and medical students. For some reason this was not provided for, although the Surgeon-General favored it and the Secretary of War recognized that some such provision was necessary. For a brief time there has been great consternation at the thought that the hospital staffs were to be still further depleted and the supply of medical students cut down nearly, if not quite, one half. If something had not been done, it would have been a very grave situation and would have represented a grave blunder. But something has been done, and so far as possible the error has been corrected. It seems desirable at this time to call attention to the provisions for safeguarding the hospitals and conserving the supply of medical students.

ORDERS

War Department, Office of Surgeon-General,
September 4, 1917.

The following regulations governing the discharge of hospital interns and medical students from drafts under the selective-draft law of May 18, 1917, have been made by the President:

"First. Hospital interns who are graduates of well-recognized medical schools, or medical students in their fourth, third, or second year in any well-recognized medical school who have not been called by a local board may enlist in the Enlisted Reserve Corps provided for by section 55 of the national defense act under regulations to be issued by the Surgeon-General, and if they are thereafter called by a local board they may be discharged on proper claim presented on the ground that they are in the military service of the United States.

"Second. A hospital intern who is a graduate of a well-recognized medical school, or a medical student in his fourth, third, or second year in any well-recognized medical school, who has been called by a local board and physically examined and accepted and by or in behalf of whom no claim for exemption or discharge is pending, and who has not been ordered to military duty, may apply to the Surgeon-General of the Army to be ordered to report at once to a local board for military duty and thus be inducted into the military service of the United States, immediately thereupon to be discharged from the National Army for the purpose of enlisting in the Enlisted Reserve Corps of the Medical Department. With every such request must be inclosed a copy of the order of the local board calling him to report for physical examination (Form 013), affidavit evidence of the status of the applicant as a medical student or intern and an engagement to enlist in the Enlisted Reserve Corps of the Medical Department.

"Upon receipt of such application with the named inclosures the Surgeon-General will forward the case to the Adjutant-General with his recommendations. Thereupon the Adjutant-General may issue an order to such intern or medical student to report to his local board for military duty on a specified date, in person or by mail or telegraph, as seems most desirable. This order may issue regardless of the person's order of liability for military service. From and after the date so specified such person shall be in the military service of the United States. He shall not be sent by the local board to a mobilization camp, but shall remain awaiting the orders of the Adjutant-General of the Army. The Adjutant-General may forthwith issue an order discharging such person from the military service for the convenience of the Government.

"Three official copies of the discharge order should be sent at once by the Adjutant-General to the local board. Upon receipt of these orders the local board should enter the name of the man discharged on Form 164A and forward Form 164A, together with two of the certified copies of the order of discharge, to the mobilization camp to which it furnishes men. The authorities at the mobilization camp will make the necessary entries to complete Form 164A, and will thereupon give the local board credit on its net quota for one drafted man."

1. It will be observed that paragraph First of the foregoing deals with interns and students who shall not have been called by a local board, and provides that they may enlist in the Medical Enlisted Reserve Corps under regulations to be issued by the Surgeon-General, such enlistment entitling them to discharge from draft if thereafter called.

2. An application for enlistment under this paragraph must be forwarded to the Surgeon-General with the affidavit of the applicant, supported by the certificates of his school authorities, showing his present status as intern or student, and particularly how long he has been an intern in the one case, or the year of the medical course that he is pursuing in the other.

3. An intern who has served one year or more as such will not be enlisted in the Medical Enlisted Reserve Corps under this regulation.

4. An intern who is enlisted in the Medical Enlisted Reserve Corps hereunder will be called into active service under his enlistment, if his services are needed, at the end of one year of internship. Applications for commission in the Medical Reserve Corps, from interns who at the expiration of one year's internship are called for duty as members of the Medical Enlisted Reserve Corps, or from interns whose year of internship is about to expire, will receive proper consideration.

5. A medical student (undergraduate) who is enlisted in the Medical Enlisted Reserve Corps hereunder will be called into active service under his enlistment, if his services are needed, upon failing to pass from one class to another, or upon failing to graduate.

6. The Second paragraph above quoted deals with interns and students who shall have been called for service by a local board under the selective-draft law, and contemplates their discharge from the draft, upon condition that they shall enlist in the Medical Enlisted Reserve Corps.

7. It will be the policy of the Surgeon-General as a rule to recommend discharge from the draft upon the condition indicated, the discharge to be followed by a call to active duty under the enlistment in the Medical Enlisted Reserve Corps at the expiration of a complete year of internship or upon the failure of the student (undergraduate) to pass to the next higher class or to graduate.

8. Interns and students who are enlisted in the Medical Enlisted Reserve Corps by virtue of these regulations, and are not called into active service under such enlistments, are required to report their status to the Surgeon-General as follows: Interns, at the end of each three months' period, such report to show the total amount of internship since graduation, and to be countersigned and attested by the Medical Superintendent of the hospital; students, at the end of each semester, such reports to show whether the students qualified for advancement, and to be countersigned by the deans of their respective schools or by subordinate officers representing the deans.

9. In the execution of these regulations the Department will not recognize internships in hospitals, sanitariums, or other institutions conducted for profit, or in small private hospitals (50 beds or less), or new internships established or added since May 18, 1917, to those previously existing, at any hospital, excepting such as may have been newly established and added by reason of a proportional increase in the bed capacity of such hospital; nor will it recognize internships in the case of any graduate appointed thereto later than August 1 following his graduation.

By order of the Surgeon-General.

ROBERT E. NOBLE,
Lieutenant-Colonel, Medical Corps.

The above provisions with regard to the exemption of interns do not apply to internships which have been established since the war began, except in new hospitals which have been opened since that time, or in large institutions where new and legitimate services have been established.

(This last paragraph is not the official text, but represents the writer's understanding of the matter.)

It will be seen from the above that interns may be exempt for one year, and medical students for the remainder of their course, provided they pass from one class to another. This does not provide for the continuation of service in hospitals of a sufficient number of interns to provide for the longer service required of a limited number to carry on the resident system. Speaking as an individual, I think this is a pity, but I am sure that whatever can be done by the Surgeon-General will be done, in order to safeguard the resident system, which has so largely been adopted by the larger hospitals.

New internships, established since the war began, will not be recognized, except in new hospitals, or established hospitals of sufficient size to warrant such exception. I am sorry to say that evidences of evasion of the above provisions make it necessary for the Surgeon-General to have the deciding voice in regard to exceptions.

I think the provisions with regard to medical students are sufficiently clear.

Now, it is apparent that in spite of these provisions, hospitals will be obliged to modify their organizations, in many instances considerably.

In the first place we must recognize that we are at war, and on a scale previously not dreamed of. All institutions must modify their organizations to meet war conditions. Hospitals must do their work with smaller staffs. Some phases of hospital work can be sacrificed temporarily if necessary, without lowering the efficiency of the hospital so far as relates to the care of the sick. In many hospitals senior medical students can be used as interns; nurses can be used as anesthetists; in fact, every legitimate device may be necessary in order to keep our civil hospitals going and at the same time provide the necessary number of physicians to the army.

Another respect in which the hospitals will suffer will be from a shortage of trained nurses. When fifteen to twenty thousand trained nurses are called into service, as they will be if the war program is carried out, there will be a shortage of trained nurses. These will be largely recruited from among those who are doing private nursing, but a considerable number will be taken from hospitals. Now, it is just as essential to keep the training schools for nurses going as it is for the medical schools. Those holding teaching positions and important executive positions should be retained if possible, but many of the head nurses will go, and they can be spared. Senior pupils must be utilized to fill their places. Larger classes should be enrolled, so that if necessary in case of great emergency, a part at least of the senior classes could be graduated early and made available for military duty. Readjustment will have to be made in this respect, as in many others.

It may be of interest to know what steps have been taken to secure the requisite number of nurses. The Red Cross nurses from the Nursing Reserve for the Army Nurse Corps. Already about 13,000 are enrolled, and they are being enrolled at the rate of nearly 1,000 a month. The standards of the Red Cross require a nurse to be between the ages of 25 and 40, a registered nurse, graduated from a school connected with a hospital of at least 50 beds. The age requirement has been modified, if the report of a special committee of the Red Cross is adopted by the War Council, so that the lower age limit will be 21 and the upper age limit will be indefinite—that depending upon the individual's fitness. The 50-bed limit is recommended to be modified, so that a graduate of any school will be acceptable, provided that school is recommended by the state board of registration as giving a course sufficiently thorough for war purposes.

Then there is the question of the need of training nurses' assistants. The special committee appointed by the War Council to consider the nursing problem has recommended that, while it is not a pressing need at the moment, should it seem de-

sirable, a special course for the training of nurses' aids should be given, this course to cover a period of one month of 8 hours each day, and that these courses may be given in any school recommended by the State Boards of Registration, as qualified to give such a course. It is expected that this report of the committee referred to, will be adopted. The Nursing Bureau of the Red Cross will then give directions and regulations governing the course. For the moment, however, the pressing need is to enroll the required number of nurses for the army, and this is going forward satisfactorily.

These are some of the factors which enter into the reorganization of the civil hospitals on a war basis. What is the specific function of the civil hospital in the military scheme, and what must they do to prepare to serve the army? That is a question which I fancy many will ask, and which I take it was intended for discussion under the title assigned to me. The present plans of the Medical Department of the Army do not contemplate the use of civil hospitals to any great extent, except in the event of a great emergency. It must be apparent that the great need of hospitals for army purposes will be in France. Our line of communication is much too long to permit of sending wounded soldiers back to this country, except when it has been determined that they are no longer fit for military duty. Even then it is planned not to subject them to the long sea trip until they are sufficiently recovered to enable them to take the trip with the minimum of discomfort and suffering.

Such a plan, therefore, means that the most of those sent home will be already convalescent, but will need reconstruction and reeducation to fit them to return to lives of usefulness, so far as possible. Will the civil hospitals be used for the treatment of these men? So far as the army is concerned, that is not the plan. It is necessary to retain these men under military control in order to keep the military records complete and to protect the government in the matter of pensions. It is furthermore desirable in order to compel those men who require it, to undergo training and reeducation in order to fit them for lives of usefulness. The experience of England and France has been that after men have been in active service at the front and have suffered the rigors of modern warfare, unless they are kept under military control, there is a tendency for them to avoid this necessary reeducation, preferring to return home, at least for a period, after which many do not return. It is strictly in the interests of the soldier that it is planned to keep him under military control until he has been readjusted or reeducated, so that he will have a place in our industrial life and may be a useful citizen. The whole plan involves the question of reeducation, vocational schools, employment bureaus, adjustment of state compensations, and liability laws—in fact, the problem is so great as to be almost staggering. It will be at once apparent to you that if this problem of reeducation and employment of the physically handicapped is solved for the soldier, it will represent a great step forward as a permanent contribution to our civic system by solving the problem for the industrial cripple and the physically handicapped individual generally.

The present plan is to use the existing government hospitals and temporary hospitals constructed for the purpose, also such existing institutions as may be turned over to the Government entirely. It is also possible that large institutions which are able to place at the disposal of the Government a considerable number of beds, say 100 or 200, may be used, in which case that part of the hospital will be under military authority, either by assignment of a medical officer, or by contract with members of the regular staff, or both. Where a whole hospital is turned over, it will be operated strictly as a military hospital. Where a portion is turned over, if it is used, it will be by contract arrangement. The present plan, therefore, does not warrant hospitals in general in going to any great length in providing for soldiers, unless it is on the advice of the office of the Surgeon-General of the Army or Navy. It is, of course, quite possible that these plans may be modified, either from choice or from necessity, but at present it is not the plan to use civilian hospitals to any great extent, except in the event that the provisions made should prove to be inadequate.

What, then, should the civil hospital do to prepare for service during the war?

It should offer to the Government as many beds as possible, but they should be actual beds, readily available and in sufficient number to be worth consideration.

It should cut down the size of its staff to the minimum, in order to release as many physicians as possible for military service.

It should organize its intern service on a one-year basis, in order to comply with the regulations laid down.

It should prepare for the release of as many nurses as possible.

It should admit as large classes as possible and prepare, if the emergency should arise, to graduate at least a part of the senior class of nurses early.

It should be prepared to train nurses' aids whenever called upon to do so.

This is merely a sketchy review of the problem, the plans for its solution and their effect on the civil hospital. It is incomplete and hastily prepared, but I trust it may give an idea to some of what is being done and what is expected.

The question may be asked, "What about those members of hospital staffs who have had more than one year's intern service? Is there any provision for detaining those men for purposes of assistant residenceship?" There is no provision for this class of men. The provision for exemption applies only to interns, and internships are recognized for only one year.

"What is the status of interns already drafted, who have on that account joined the Reserve?" They are subject to exemption, if needed, to man civil hospitals, but only for a period of one year.

"Should interns and medical students who have not been drafted enlist now, or should they wait until drafted and then enlist?" There is no object in having these men enlist now. There is provision for them in case they are drafted, and if they enlist now, then their services cannot be retained after a period of one year. If they do not enlist now, and are not drafted, then these men will be available for longer hospital service until they are drafted.

In order to safeguard the hospitals, so far as possible, and to provide at least a minimum number of men with hospital experience, who may be available for the senior positions on the staffs, it is recommended that interns and medical students, who have not been drafted, should not enlist in the Enlisted Medical Reserve Corps at this time, as no particular purpose is to be served thereby, and there is a provision which will cover them in the future, provided they are drafted.

It is apparent that the hospitals which have established a residence system, or systems which provide an organization for a residence staff which includes men who have had more than a year's internship, will be obliged to reorganize on a basis of one year's internship, excepting such men of upper staff as are not caught in the draft.

The school nurse is not a passing experiment. She is a vital part of one of the most important of our national institutions. Through her work American citizens are physically fitted to receive the education which in its turn is to fit them for the responsibilities of citizenship. It is her duty to so teach the value of health both to children and parents as to make them realize that its attainment is worth some real sacrifice on their part; it is her duty to strengthen parental responsibility in new directions. It is her duty to strengthen the hands of teachers and physicians, and also to do her part toward making the American school an institution where bodies, as well as brains, are developed for a life of usefulness.—Mary S. Gardner, "Public Health Nursing."

SYPHILIS AND THE GENERAL HOSPITAL

Change in the Attitude of Hospitals Toward the Syphilitic —Closed Wards and Out-Patient Departments Preferable

It is estimated, says Dr. Henry Rockwell Varney in a recent number of the *Journal of the American Medical Association*, that from 15 to 25 percent of the patients admitted to all departments of the general hospital are syphilitic. In view of this percentage, based on Wassermann tests and clinical symptoms, the rejection of known syphilitics becomes absurd. It is gratifying to note that this narrow and short-sighted policy is much less prevalent than it was twenty-five or even ten years ago, and that increasing numbers of general hospitals are not only treating the syphilitic, but also educating him and the interns and nurses on this service as well.

The most successful hospital service for the syphilitic, in Dr. Varney's opinion, is the restricted general hospital with closed free wards and closed out-patient service. The medical service should be continuous; responsibility should be definitely placed on the chief of the service, with a carefully selected corps of assistants. Both interns and social service nurses should receive special instructions.

Record is made of all syphilitics who enter the restricted wards or out-patient departments. This registration supplies valuable data for the community and enables the hospital to follow up its cases; and the patient makes no objection to registration because the hospital records are private. Not only is the patient treated, but his family is examined and any members found infected are treated also. Under this closed system patients do not lose valuable time through the inattention due to shifting of responsibility entailed by rotation in service. Thus the confidence of the patient in his physician, which is of the utmost importance in this disease, is not impaired.

Save Soap and Time

"Good, pure soap and lots of it," is the motto in most laundries. This should be changed to "Good, pure soap and little of it."

One example of the inconsistency of the policy of using "lots of soap" is found in the statement of the head of one of the wash rooms in which quick, special work is turned out. He says, "I throw lots of soap in the wheel so as to get a big suds quick. I can't wait for a slow suds."

This man, in trying to save time, fills the linen with soap, which, in the succeeding rinsing process, he hasn't the time to remove. Good washing is 99 percent rinsing and 1 percent soap. The less soap you use, the easier it is to rinse. Soap is a hard rinser. If it remains in the fabric it will ruin the goods, and if you apply the only alternative of using acids to remove soap and shorten the time of rinsing, you also ruin the clothes.

Experience has proved that too much soap is at the bottom of the trouble—either through the soap remaining in the goods, or to the acid used in removing the soap. Too much rinsing also causes wear, although this is the least of the three evils. So what are you going to do?

The answer is washing soda—the double detergent. This removes soil and grime quickly—and rinses ten times more quickly than soap. Use only a light suds of soap. In other words, don't use enough soap to make suds. Use soap until you see the suds coming—and stop right there.

"Trouble knocked at the door, but, hearing a laugh within, hurried away."

THE CHEMISTRY OF MODERN WASHING

After Much Evolution Old Principles Are Back Again—Of Great Interest to Hospitals

BY ALLEN ROGERS, Committee Chairman Pratt Institute, Brooklyn.

Through the efforts of the Committee of the American Chemical Society, many points of general interest are being brought to the attention of the general public through the daily and technical press. It is a common saying that in time the most complex invention comes back in principle and even in form to the simple elemental type from which it was derived. Something of this kind of "reversion" has certainly taken place in the apparently simple process of getting things clean. These cleaning processes vary in character from the everyday washing of clothes to the washing of automobile rims before finishing; from the washing of wool as it comes from the back of the sheep to the washing of a man-of-war's deck.

In earlier times, when an article was to be cleansed, it was washed with the aid of soap, as a matter of course, and no thought was given as to why soap should be a cleansing agent. These early soaps were efficient cleansers, but in many cases were hard on the materials that were cleansed. Certain kinds of "dirt" were removed not by the soap, but by mechanical action, and often the cleaning was accomplished only by the wearing off of the contaminated surface of the article being cleaned. These earlier soaps were rather crudely made from mixed fats, and the homely processes used generally insured a large excess of free alkali. The early source of the alkali was principally wood ashes, which contained considerable amounts of potash. Later, about 1823, artificial alkali, which was in the form of caustic soda, began to be used in England. This soda alkali had the advantage of producing a hard soap and in many cases was not so destructive on the articles that were cleansed. Later, the fats used in the manufacture of the soap began to be selected; then soaps containing but very little excess alkali were produced, and it was found that these soaps did not have the cleansing power of the earlier soaps which contained the excessive alkali. It therefore became the custom to incorporate varying amounts of soda ash or other mild forms of alkali in soap, but time proved that in many cases these forms of alkali were still too strong.

As the population became more congested, there were developed commercial cleansing organizations which made a business of cleansing various articles for the public. With this development the people became more critical as to the efficiency of the cleansing operation and the attack on the goods cleansed. Naturally, therefore, attention was directed to securing efficient cleansing without destruction of goods. It was found that alkali had a distinct function in the operation and that in many cases the cleaning could be entirely effected by the alkali alone. In other cases it was found that the operation could be divided and that the use of the alkali in a separate operation gave increased efficiency and a lower cost. In these investigations it developed that the soap acted in a more or less mechanical manner and removed only such materials as could be washed away in a solid state or in an emulsion. It was found that some of the "dirt" was "set" in the goods and made more difficult to remove by the action of soap, but that if the goods were treated first with some form of alkali this material would be taken out.

It was found that various operations required soda of varying character, and that the soda alkalies were in most cases fully as efficient as potash alkalies and more economical to use. Hence the use of alkali in cleansing resolves itself almost universally into the use of soda in cleansing. In the cleansing of textiles, it was found that under ordinary working conditions the action of caustic soda or lye and soda ash was too harsh, and as a result of the milder forms of soda, such as borax, came to be used.

This, however, was expensive, and later there was developed another form commonly known as sesquicarbonate of soda, which was an efficient cleanser without unduly attacking the goods cleansed. On account of the difficulties of manufacture of the sesquicarbonate, many firms made up mixtures of soda ash and bicarbonate of soda approximating the composition of sesquicarbonate and possessing more or less of the properties of that compound. These materials have a very mild action and are especially adapted to all cleansing operations in which soda is suitable, in which the materials to be cleansed would be attacked by alkalies as strong as soda ash or in which the operator's hands come in contact with the cleansing solution, such as in the cleansing of containers and apparatus in dairies and creameries, and other food containers.

With the increase in the marketing of food products or beverages in bottles and the increase in size of the plants producing these materials, machines were developed for the automatic cleansing of the bottles used. It was found in this case that a strong form of soda was required to give efficient results, and for this purpose caustic sodas or mixtures of caustic soda and soda ash are generally used. It has been found that soda is applicable to many other cleansing operations in which it shows advantages in economy and efficiency of cleansing. Some of these domestic purposes are the cleansing of unfinished wood floors, tile floors, marble walls and fixtures, and the washing of dishes in hotels and restaurants, in dish-washing machines.

Thus it is seen that the cycle of change has led from the early soaps containing alkali by accident through the refined neutral soaps without free alkali, the soaps to which artificial alkali was added by design, and, finally, to the modern neutral soaps used in conjunction with special alkalies. We are back in principle to the earliest usage, but with this difference: we know now the function of the soap and the function of the alkali, and their use in one operation or in separate operations is as much a matter of science as, let us say, the building of a battleship.

Unquestioning obedience and conformity to rules are among the most important lessons learned by the pupil nurse during her hospital training, and make an indispensable foundation on which to build other desirable characteristics, but the superintendent who would have a really strong staff must not be content with a set of obedient children content to do her will, no matter how perfectly. Her best security from the danger of an autocratic rule lies in the development of a body of women who will think for themselves, and whose ideas and theories are so valued as to become a part of the very warp and woof of the association. In this way only can esprit de corps be developed, and in this way only will united strength be achieved. If these ends are gained, a superintendent may well feel that she can sing her nunc dimittis, for the welfare of the association will rest on no ephemeral advantages, nor on the personality of any single individual, but will be secure in the united strength of all its workers.—Mary S. Gardner, "Public Health Nursing."

The
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The Cleveland Meeting

Elsewhere in this issue and in succeeding issues of THE MODERN HOSPITAL papers read at the Cleveland meeting will be published. It was a wonderful meeting we had at Cleveland, and under the spur of the critical situation of the country, because of the war, we got down to fundamentals in the discussion of vital hospital problems to a degree that would not have been attained but for the peculiar and unusual situation in which our country finds itself.

From the very moment that delegates to the convention began to arrive in Cleveland up to the last moment of the last departing guest of the night of the last day, a spirit prevailed full of calm determination on the part of everybody to learn what was expected by the hospitals of the country and to do that thing and to do it well.

Heretofore at our conventions there has been a rather insistent demand for the lighter side of convention life, for features of entertainment, diversion, recreation, and sight-seeing; this time the very air itself was fraught with a seriousness that left no time or inclination for frivolities or social features. War, in the past, has always brought with it momentous epochs for the hospitals wherever the war occurred; indeed, every evolution in hospital progress seems to have dated from a war. The Cleveland meeting was typical of the birth of such an epoch. Without question the meeting at Cleveland brought a new turn in the affairs of the civil hospitals. At that meeting a new spirit, new methods, new inspiration were born. A warning was sounded at the meeting that inefficiency, uncertainty, and purposelessness could no longer be patiently borne, and those who were at the meeting knew when they left for home that new responsibilities were upon them and that they were to be measured in their administration by new rules; that the old days of shiftlessness and easy-going ways were ended; that those who could not measure up to the new order of the day would have to step aside and make place for others who could measure up to the demands of the time; that there was to be no more of "I can't," and that "I will" was to take its place.

If the War Department's views as to the new duties of the civilian hospitals are accepted—and they must be—the next few years are to reveal a new mark in the hospitalization of the civil population. Heretofore only 10 or 12 percent of the people of this country who were frankly sick and in need of a doctor went to the hospitals; now that the medical profession must be drafted for the war, and the nursing profession as well, it is to be necessary that many times more sick people must go to the hospitals and out of their homes, in order to get proper care. If this means anything, it must mean a tremendous growth in the number of hospitals and in bed capacity of those that are now in existence. The question is whether we hospital people are big enough and broad enough and efficient enough to answer the country's call and "do our bit." THE MODERN HOSPITAL answers this question in the affirmative. We are big enough and broad enough, and we are efficient and well trained in our duties and will measure up to what the country demands of us.

The Dispensary as a Factor in Public Health Work

Dispensaries in the English-speaking world began at the end of the seventeenth century as centers from which medicines were distributed to the poor. Then they advanced to be institutions in which medical advice and treatment were furnished and the giving of medicines became incidental. Not until the end of the nineteenth century did they become factors in public health work.

It was the antituberculosis movement that began it. In 1900 there were in the United States about three clinics for the diagnosis and care of tuberculosis; in 1905 the number had increased to nearly twenty; twelve years later there were five hundred. This rapid increase is evidence of

the growth of the organized movement to cure and prevent tuberculosis; but it is also an indication of something more: it manifests a new point of view with reference to the dispensary itself.

The original dispensaries were medical soup-kitchens. The very poor, the down-and-outers, were expected to come and get advice and a prescription. But with the growth of medical science, in power to prevent wholly or largely in number of diseases, a new point of view has arisen, which now dominates all progressive public health work. This point of view is not the passive attitude of the old dispensaries or of the old public health departments. The modern public health department does not merely wait until complaints come to it; it feels the responsibility of being an active factor in the community. So the tuberculosis dispensary starts in a neighborhood as part of an aggressive attempt to find all the cases of tuberculosis that it can and to cure and prevent all that it can. It is a militant agent.

So, too, have been the babies' dispensaries, or "well babies' clinics," which, hardly existing ten years ago, now dot our large cities and have spread to many small ones. The same spirit of militant endeavor to reach those who need service animates the clinics for mental diseases which are being connected with our hospitals for the psychopathic and the insane. So with the prenatal and obstetrical clinics which maternity hospitals and public health departments are annually establishing in increasing numbers; so with the dental and other clinics for caring for various diseases of childhood; so with many dispensaries attached to industrial establishments. These dispensaries are all part of a determined and conscious endeavor to do what the advertising man calls "get out after the business."

We may expect these types of dispensaries to develop further in this country. The war will expedite rather than hinder their development. To prevent tuberculosis and infant mortality is more important to a nation during war than during peace. So also the diagnosis and treatment of venereal disease will probably enter into the work of dispensaries in a much larger degree than heretofore, because of enhanced realization of the need for dealing with this problem.

But how has this militant public health spirit affected—how should it affect—the large out-patient departments of the great general hospitals? How should it affect the dispensary which is independent of a hospital? How it should affect the out-patient department of the hospital in the moderate-sized town? These out-patient departments and dispensaries have been increasing in number and in importance in recent years. Their technic, while still often open to criticism, has improved. To what extent are they—and to what extent can they be—factors in the direct promotion of public health and in the prevention of disease?

The general dispensary or out-patient department has large opportunities for preventive work. In the first place, the dispensary reaches disease in its earliest stages. Hospital wards receive the patient when he is acutely ill, when the disease is advanced, when it is often too late to do more than treat the final symptoms or perform the radical operation. If the dispensary does good work for its patients many hospital cases will be avoided, many workers can be kept at their daily tasks with benefit to themselves, their families, and their employers.

The dispensary is a means of supervising the convalescence of hospital patients or patients recovering from disease in their homes. It is a means thus of promoting health and of saving money for the community by keeping people under medical supervision during that period when they are likely to overdo and cause relapse into serious illness.

Then, again, the host of minor diseases, which never enter a hospital and which those of moderate means will rarely take to the private doctor, come to the dispensary in numbers. The treatment of minor disease is often a preventive of serious disease and is also worth while for its own sake. Minor diseases diminish the comfort and the efficiency of the adult. They are a drag upon the development of healthy childhood.

In all these relations to the early stages of disease, to minor illnesses, and to convalescence, the dispensary is a factor in public health work exactly in proportion as it performs its medical functions efficiently. A social service department is an essential element in a good dispensary, both for curative and for preventive work; but the social service is of importance to the institution primarily because of its contribution to medical results. Good medical service, accurate diagnosis, effective treatment—these are the foundation of all work in the dispensary, and the basis of its usefulness as a public health factor. Hasty examination of patients, loose prescribing, inadequate follow-up systems, are fatal to the realization of the dispensary's service in either cure or prevention. Because the dispensary reaches hundreds or thousands of persons, it has a large opportunity to teach as well as to heal—to distribute health literature, to inform families as to the

nature and spread of contagious diseases, to instruct mothers in the care of children, to educate housewives, these trying days of war prices, in the better selection and preparation of food.

The realization of all these and of many other public health possibilities of the dispensary depends on its medical efficiency and also on its possessing the militant attitude toward the health of the people. No medical institution can afford to be passive these days. To conserve and promote health is a national asset in hours of peace, but a national need in time of war.

MICHAEL M. DAVIS.

The War This Month

The event of greatest interest to the hospitals that has happened in connection with the war during the past month is the publication by the War Department of a scheme by which hospital interns, and incidentally medical students, are to be exempted from service either in the medical corps or in the drafted army. This has been a matter that has caused very great concern in medical and hospital circles. Dr. Goldwater, representing Mayor Mitchell's state council of defense, has been at the head of a propaganda for the past month to bring about this exemption of interns.

The provost marshal general has been unable to see his way clear to exempt interns from the processes of the draft law, and great numbers of these young men who had been drafted have applied for and obtained commissions in the Medical Reserve Corps, and in every instance they were compelled to subscribe themselves as ready for immediate service for war duties. The carrying out of this process would have almost cleaned out the hospitals of the country so far as interns are concerned, because practically 90 percent of hospital interns are within the draft age, and most of them are physically and professionally eligible for war duty.

It has been agreed now that these interns may join the Medical Reserve Corps with the understanding that they will be permitted to serve out their internships before being called into active service. The exact process is that they place themselves at the disposal of the surgeon-general, who has always been heartily in favor of keeping interns in the civilian hospitals until their internships had been served.

Hospital superintendents need have no fear now of losing their interns; before this announcement is published the exact mechanism by which these exemptions are to be had will have been issued by the surgeon-general. At the present writing that machinery has not yet been announced. The same order carries with it the exemption of medical students in their second, third, and fourth years. This decision regarding both students and interns has very far-reaching significance. Great Britain at the beginning of the war depleted her medical schools, sending the students into the line army, and this has resulted in the utter stagnation of medical education in Great Britain, to so great an extent even that the civilian population of Great Britain is now suffering intensely for want of medical attention. On the average, in the British Isles there is only one civilian doctor to every 6,000 population. In this country we have about one doctor to every 500 population. The United States population has been appealed to by the British to furnish physicians to take care of Great Britain's civil population for the period of the war, and our War Department is now energetically preparing to furnish some 3,000 doctors for this purpose.

At the beginning of the war, Great Britain's interns were all sent into the army medical service, and civilian doctors who were past the age of active service were sent into the hospitals to attempt to carry on the work of interns, with deplorable results. Great Britain's medical schools are now made up of foreign students, Chinese, Japanese, East Indians, and representatives from nearly every part of the orient.

The action of our War Department will undoubtedly have the effect of conserving our medical resources and of continuing the education of young men for the eventuality of the continuance of the war over a long period.

The Hospitals and the War

Major Winford H. Smith, Medical Reserve Corps, in his address on "The Organization of Civilian Hospitals for War," told the Cleveland convention just exactly what the country expected of the hospitals and what their limitations of service were to be.

The civilian hospitals are not to prepare themselves to care for the wounded and sick soldiers of the war; they are not to be pressed into the service as war hospitals in any respect. This plan may be changed later on as conditions change, Major Smith stated, but the government, at the present time, contemplates caring for sick and wounded soldiers and sailors in specially prepared government military and naval hospitals.

The duty of American hospitals, as Major Smith outlined them on the authority of the Surgeon-General of the Army, is to be summed up as follows:

1. To release the largest possible number of

medical staff members for service in the Medical Reserve Corps of the Army and to make good their loss by the addition of other men in civil life in the community who are ineligible for military service and who can render good service to the sick in the several branches of medicine.

2. To arrange for the release of the largest possible number of interns compatible with the maintenance of good service to the civilian population.

3. To release the largest possible number of trained nurses and to fill their places in the hospitals by bringing in untrained young women as pupil nurses.

4. To release the largest possible number of scientifically trained heads of the various hospital departments for war service and to fill their places by bringing in other and partially trained men and women to get the continuance of their training in the hospitals.

5. To release the largest possible number of trained orderlies and other hospital help for war purposes and to bring in and train others who are not now trained.

6. To perfect the organization of the civilian hospitals to the highest possible point in order to take care of a larger percentage of the civilian population, in order that the time and energy of doctors and nurses may be concentrated in the handling of large numbers of patients in groups instead of singly and at their homes.

7. To improvise the necessary number of additional beds to take care of this larger percentage of the civilian population.

8. To bring down the per capita costs of hospital maintenance to the lowest possible figure commensurate with the highest possible order of scientific service, in order to release more and more funds for the benefit of the sick and wounded of the war.

9. To conserve supplies and hospital commodities in order to leave that much more for the purposes of the War Department.

10. To buy whatever supplies and commodities may be necessary in the most judicious manner possible in order to interfere as little as possible with the needs of the army and navy.

In brief, these are the duties of the civilian hospitals for this war, as indicated by Major Smith in his address at Cleveland, under the inspiration of the War Department. The message of the Surgeon-General to the civilian hospitals of the country, as transmitted by Major Smith, was so clear and concise that every civilian hospital, its superintendent, its board of trustees, and its financial supporters may know just exactly what to do, how to do it, and the result that may be expected. If not one other thing was done at Cleveland, this message was more than justification for the great gathering of hospital people there.

THE MODERN HOSPITAL suggested editorially, prior to the Cleveland convention, that the problems indicated above were pressing and insistent and that the meeting must be held this year even though we are in the midst of war and all of us busy with many other duties and obligations. The results of the meeting are extremely gratifying and satisfying, and to that extent the Cleveland meeting was a success perhaps beyond any other meeting of the association that has ever been held.

Preparedness for Actual Fighting

The daily papers are keeping our readers so well posted on the preparations of the new national army, the transfer of the National Guard over to the federal service, and the provisions for housing, feeding, and training this army of more than a million men that it is unnecessary for us to dilate on this feature. Some things have transpired, however, that are of great interest to hospital people and that are not published in the newspapers. One of these is the preparation and forwarding of ambulance companies to the western war front. Col. Jefferson R. Kean, director of the Red Cross for the first period of war preparation, was assigned about a month ago to take charge of the ambulance service in France and Belgium; he has been over there for approximately a month, getting ready to take over the ambulance service for the British, French, and American armies. In the meantime a very large number of ambulance companies have been organized, some of them in connection with the national army and a great number under the National Guard of the several states. These companies are being fitted out as rapidly as possible and made ready to go across the water; some of them have gone and are already in France.

No new base hospitals have been sent abroad during the past month; only the original eight are now over there, and field hospitals have not been forwarded. The war departments of Great Britain and France, acting in unison with our own national authorities, have agreed that the best service we could render at this time is to send individual medical men; several hundred of these men, all under forty years of age, are now at training camps learning the methods and mechanism of the military service with the intention of the department that they shall go to the front at the earliest possible moment. Other men are being sent over without diversion to the training camps. Most of these latter are the younger men, recently out of internships, from the best medical

schools, nearly all of whom have had some military training, at least in the "paper work" of War Department duties. These men, upon arrival in France and Belgium, are being sent to different stations, some into base hospitals, which were undermanned, some to field hospitals near the front, and some to first-aid and dressing stations in and about the trenches. Already, we are assured, the dearth of medical men in the British and French armies has been very greatly relieved by the accessions from this country.

If our civilian hospital authorities are wise, they now have an opportunity to strengthen their home staffs gradually, and it ought not to be the occasion for letting down the bars to poorly equipped and undesirable men on the assumption that it is only a temporary measure. We can well conceive that it is not a temporary measure. Already, we who are in close touch with the hospital pulse of this country are realizing a tremendous impetus in the growth of our civilian hospitals. As we have so frequently said, the records show that only about 11 or 12 percent of the sick who are in need of a doctor were taken to the hospitals, at the outbreak of this war, three years ago. That means that 88 or 90 percent of the sick people of this country were being cared for in their homes, an inconceivable thing in view of the fact that in this modern day of scientific medicine nearly all of the accessories and facilities for diagnosis and treatment are assembled in the hospitals and nowhere else; and it is quite certain that no sick person nowadays can get adequate attention in even the most luxuriously appointed home.

Therefore, an era is upon us the outstanding feature of which is that rich people and those in moderate circumstances who can pay a reasonable price for hospital service are now to demand that service, and almost before this war is over we may safely predict that vast numbers of our people will have been converted to the hospital habit. This means that with the close of the war and the reestablishment of normal prices for construction material and labor, there is to be a tremendous growth of our hospitals.

If this means anything, it means that this emergency should be taken advantage of by hospital authorities to reconstruct their establishments in so far as the administrative personnel is concerned. We can get along with architectural deficiencies even in the presence of a tremendous influx of new patients, but we cannot get along and give an adequate service to the sick unless our administrative forces are capable, well organized, and well drilled. This is no time for hospitals to let down the bars to inferior medical men or young women of mediocre character and attainments for training school purposes.

Warning Against Picture Takers Pretending to Represent The Modern Hospital

For a year or more some one has popped up every once in a while, in some hospital in the country, introducing himself as the representative of and photographer for THE MODERN HOSPITAL and has asked for the privilege of taking pictures about the building, which he has invariably said were to be published in this journal. This incident has been repeated many, many times; in every case the request of the visitor has been complied with, and in no case have the pictures ever reached THE MODERN HOSPITAL.

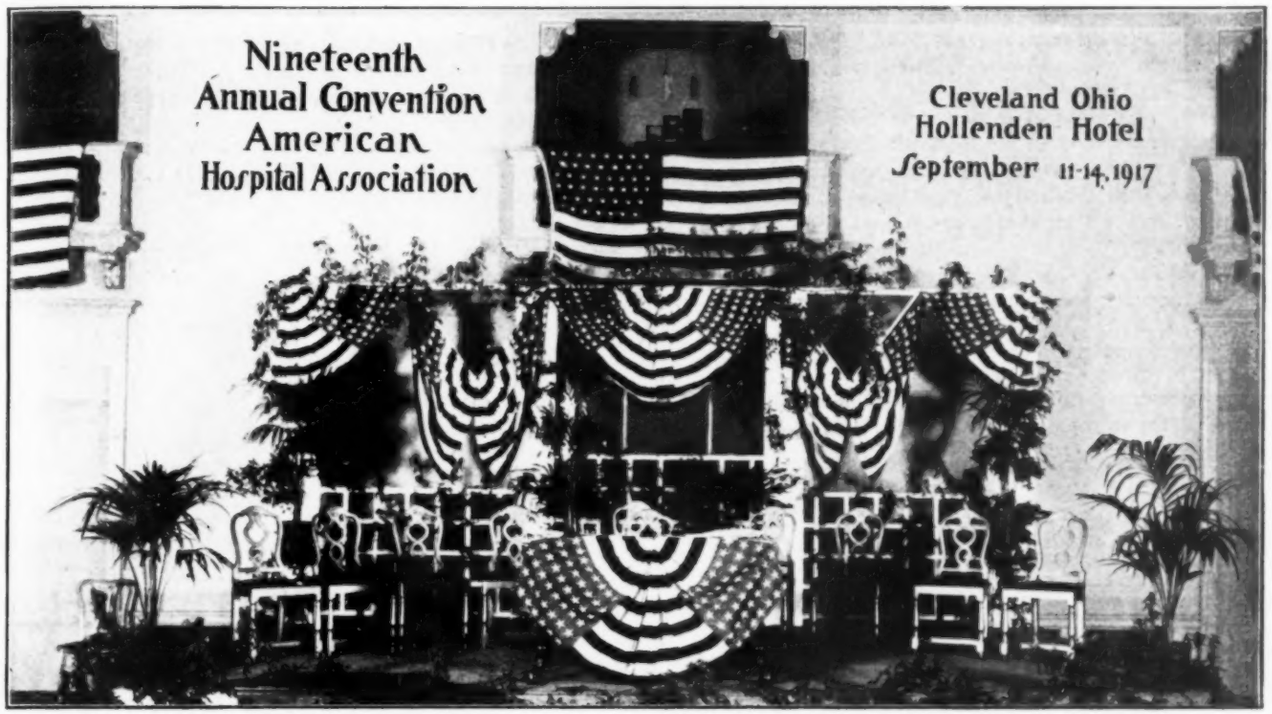
It ought to be known that representatives of THE MODERN HOSPITAL visiting hospitals will always have credentials with them, and superintendents of institutions are warned especially against photographers representing themselves as our agents. We have no official photographers on the road anywhere, and if, as occasionally happens, we give a commission to a photographer in some city to take photographs for us in some particular hospital, he will also have a telegram or a letter as his authority, as representative of this journal.

There seems to have been no attempt on the part of this mysterious visitor to defraud, and we are at an utter loss to know just what "the game" is, but please be warned.

The Public Is All Right

At a recent meeting of the British Hospitals Association in London, Viscount Sandhurst, the president, in recounting some of his own experiences in the course of thirty-six years' work in voluntary hospitals, said he had come to the conclusion that the public always had confidence in a good hospital, and, whatever its financial troubles were, would always see it through sooner or later. "And," he added, "if the public did not come to the rescue, then something was wrong with the institution."

Lord Sandhurst was not speaking of American hospitals, but he might well have been doing so, because that same experience and that conclusion is common to us on this side of the water; if the public fails to support a hospital, it is certain to be the fault of the hospital, and not of the public. Those whose hospitals are in financial difficulties may well take this to heart.



CLEVELAND MEETING TAKES UP VITALLY IMPORTANT TOPICS

Role to Be Played by Hospitals of the Country in the Present World Crisis Defined—Novel Features of the Convention

The most vitally important meeting ever held by the American Hospital Association ended its four-day session in Cleveland, Ohio, on Friday evening, September 14.

For eighteen years the American Hospital Association has met annually and has discussed the living and actuating problems of hospital architecture, equipment, and management to the very great profit and benefit of the sick and of the hospitals themselves. But all the meetings heretofore held by the association have concerned the existence and the progress of the hospitals in times of peace. Progress and improvement have been steady and gradual and almost no convention has ever had to face an epoch like this.

The world is at war and the part of our own country in that war is growing in importance and is rapidly taking on the form of tragedy. The hospitals of our country are on the tide and are being hastened into conditions never before approached—facing a time when billions of dollars are being drawn from the public pocket to win the war and many thousands of medical men are being called to care not only for our own sick and wounded soldiers, but also for those of our allies, when many thousands of nurses and trained hospital people are being drawn for the same purpose, depleting our hospitals of the scientific and trained personnel necessary to their conduct, and when the vast funds, amounting to nearly a billion dollars a year, needed for the operation of American hospitals are being diverted into other channels. These were the conditions facing the hospital people in their meeting this year at Cleveland.

What was to be the part that our hospitals were to play in the tragic history now in the making? What were they to do to help win the war? These problems were uppermost in the mind of every hospital administrator and every trustee until the Cleveland meeting. Now the answer has been given, and every hospital administrator who took the train from Cleveland at the close of the convention knew just exactly what the part of his hospital or her hospital was to be in the face of the war, and what action was necessary to be taken. This is what the Cleveland convention accomplished.

When President Wilson dropped his gavel at nine o'clock on Tuesday morning, September 11, there faced him in the large assembly hall of the Hollenden Hotel more than 500 hospital administrators; the halls and corridors outside the convention room were filled, the lobbies of the hotel were crowded with an eager throng, and it seemed for a time that hotel accommodations were not to be had. Eventually, however, Cleveland took care of the more than 1,200 people who had assembled for the convention and did it in a splendid and most hospitable manner.

Cleveland had prepared for the convention. The decorations of the assembly hall were beautiful and imposing; American flags, artistically draped, decorated the platform; festoons of green and the national colors were interwoven about the walls. Masses of flowers were everywhere.

The arrangements for the convention were not quite so happy as were those in Philadelphia last year, but only because the architecture of the Hollenden Hotel did not permit so convenient an arrangement for the meetings of the convention and for the commercial and the non-commercial exhibits. It seemed, at first glance, as though the commercial exhibits were better situated than last year because large numbers of them were grouped in the immense assembly hall itself and others were installed beyond the great archways and in alcoves beyond. It was

unfortunate that this arrangement made it impossible for visitors to the exhibits to pass to and fro among the exhibits and to talk and ask questions while the meetings were going on.

The non-commercial exhibit was forced off through a remote corridor and in an inconspicuous place, difficult to find, a fact that was greatly to be regretted because the non-commercial exhibit this year exceeded anything that had ever been attempted before; indeed, it was well worth careful study.

The registration rooms were immediately at the entrance of the assembly hall and were in charge of trained young women, who handled the business of registration with promptness and efficiency.

THE MODERN HOSPITAL BUREAU OF INFORMATION

The Bureau of Information and service conducted by THE MODERN HOSPITAL was installed in a large, well-lighted, well-planned room just next to the registration booth, and it may be said with becoming modesty that this bureau was an attractive, interesting, and an important feature of the convention, a feature that must grow with each coming year and must be ever more important and necessary. Heretofore it has been the privilege of vistiors to the convention to ask questions of each other and talk over their hospital problems, but never before have arrangements been made whereby visitors could have the use of writing room and materials, chairs and alcoves for carrying on conversation and visiting. Visitors proved desirous of ascertaining the presence or absence of acquaintances that they hoped to meet at the convention and were enabled to locate them. Note was taken for use on future occasions that a large number of inquiries were made for visitors grouped geographically; for example, a person would inquire for all those who had registered from Detroit. Thanks to the local knowledge, tact, and energy of Miss Celia Kessler, a member of the Mount Sinai Hospital clerical staff, whose services were kindly lent by Mr. Chapman, this bureau proved of considerable utility to the visitors. Local information of all kinds and that relating to transportation were much in demand, and Miss Kessler's courtesy and attentiveness under high pressure demonstrated to all visitors to the convention what an ideal telephone operator should be.

Above all, arrangements have never been made before whereby visitors could see hospital plans and hospital photographs. This year many of the best hospital architects in the country were pleased to send their best hospital plans for exhibition purposes, and the rooms of THE MODERN HOSPITAL bureau were full of well-indexed and well-placed hospital plans, classified so that visitors could see great numbers of plans of any class of hospital in which they were interested. The following architects were represented: Olof Z. Cervin, Rock Island, Ill.; Crow, Lewis & Wickenhoefer, New York City; Gibb & Waltz, Ithaca, N. Y.; Harold F. Kellogg, Boston, Mass.; Ludlow & Peabody, New York City; McKim, Mead & White, New York City; George B. Post & Sons, New York City; Schmidt, Garden & Martin, Chicago, Ill.; F. W. Striebinger, Cleveland, O.; Meyer J. Sturm, Chicago, Ill. The Minnesota Advisory Commission of the State Sanatorium for Consumptives had a large exhibit of plans and perspectives of sanatoriums of various sizes.

This exhibit excited considerable interest and there were many visitors to it, especially in the evenings. It is to be hoped that this feature will be developed at future conventions, and that, with the cooperation of the architects, a guide to the display will be prepared, so that visitors may find those parts in which they are most interested. It would also be useful if plans of special units could be shown together. There was a special demand for plans, photographs, and details of equipment of general and diet kitchens. Inquiries were also numerous for psychopathic and contagious disease hospitals.

The social features of the convention at Cleveland were, as they were expected to be, reduced to a minimum as to variety, but those that were permitted were of deep interest and were immensely enjoyed. Mr. Chapman and Mount Sinai Hospital formed an entertainment host at the luncheon held in that institution that will be long remembered by those who had the privilege of enjoying it. Mount Sinai Hospital is a beautiful institution, new, and as designed by Dr. Goldwater has many features that were of great interest to the visitors; indeed, it was a liberal education to be privileged to go through the hospital. Mr. Chapman's luncheon, held on the lawn and served by the nurses, was an innovation, something like that given to us at San Francisco two years ago on the lawn of the county farm, where huge piles of native fruits and a most delicious luncheon, served by bevies of nurses from the various city institutions, formed one of the features of the great San Francisco meeting. Mr. Chapman's luncheon will be remembered, as that other luncheon is remembered, with great pleasure.

OFFICERS OF THE AMERICAN HOSPITAL ASSOCIATION FOR 1917–1918

PRESIDENT,
DR. A. B. ANCKER,
Superintendent St. Paul City and County Hospital,
St. Paul, Minn.

FIRST VICE-PRESIDENT,
DR. A. R. WARNER,
Superintendent Lakeside Hospital,
Cleveland, Ohio.

SECOND VICE-PRESIDENT,
MR. E. S. GILMORE,
Superintendent Wesley Memorial Hospital,
Chicago, Ill.

THIRD VICE-PRESIDENT,
MISS GRACE FAIRLEY,
Montreal, Can.

SECRETARY,
DR. WILLIAM H. WALSH,
Philadelphia, Pa.

TREASURER,
MR. ASA BACON
Superintendent Presbyterian Hospital,
Chicago, Ill.

TRUSTEES,
MR. RICHARD P. BORDEN,
Trustee Union Hospital,
Fall River, Mass.

DR. WINFORD H. SMITH,
Superintendent Johns Hopkins Hospital,
Baltimore, Md.

MISS MARY L. KEITH,
Superintendent Rochester General Hospital,
Rochester, N. Y.

The visit to the Cooley Farms was another feature that hospital people will not find duplicated anywhere on this continent. The plain stucco buildings of modern architecture and the two thousand acres of high rolling farm were a marvel to see, and, more than all else, Cleveland's foresight and thoroughness in looking after its dependent sick out in the country could not help but be admired. The lesson learned there will go home with everyone who attended the meeting, as an illustration of the goal to be sought by other communities in their endeavor to serve the sick.

A great many visitors went to Lakeside Hospital and there saw one of the best administered and one of the most complete hospitals in the country. It is to be regretted that the new building for Lakeside is not yet erected. It is to be a magnificent, three-million-dollar institution, in keeping with the prominence of the city and its already great size and importance and the generosity and humanitarianism of its people.

The local committee is to be sincerely congratulated upon the completeness of all arrangements for the convention; on its physical side the convention was a great success; there were no hitches anywhere, no embarrassments of any kind, and the hospitality of all the people, and the attentiveness of those whose duty and pleasure it was to look after guests at the convention were all that could possibly be desired. As a whole, the Cleveland convention will mark one of the high points of importance and interest to the association.

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WHAT WAS DONE AT THE CLEVELAND MEETING

Scientific and Business Program of One of the Most Successful Conventions in the History of the American Hospital Association

BY ROBERT J. WILSON, M. D., New York, President of the American Hospital Association.

In the absence of the mayor, the director of public welfare, Lamar T. Beman, on his behalf welcomed the association to the city and pledged the city to cooperate in every way with the association to make the convention a success for the good of the hospitals and the welfare of the country. On his own behalf, the director of public welfare, having charge of the city's hospitals and correction institutions, notified the association that the various heads of the divisions under his control had been instructed to welcome the members as visitors irrespective of visiting hours and to afford them every opportunity to study the character of the buildings and their modes of administration.

The response to the address of welcome, made by Dr. J. W. Fowler, of Louisville, Ky., was replete with poetic reference to the city of Cleveland and its people. The report of the secretary, which was in reality the minutes of the previous annual meeting, as well as the minutes of the meetings of the trustees, suggested various changes in the constitution and by-laws that did not materially change their general intention, but did give opportunity for more systematic and businesslike methods of keeping the records of the association.

The report of the board of trustees recommended an amendment to the constitution giving a broader definition of its aims and objects, with the end in view of incorporation either by act of Congress or under the law of the District of Columbia. This report also gave a concise account of the work accomplished by the trustees during the past year, the most important item of which was the effort used in connection with the adequate solution of the problem regarding the exemption of medical students and hospital interns who had been called to military service under the draft law.

The paper of Dr. Donald E. Baxter on the "Organization and Direction of After-Care for Poliomelitis" was a description of the methods observed by the New York committee on this subject in preparing for the close observation, proper registration, and medical supervision of the cases of paralysis resulting from the epidemic of anterior poliomyelitis which occurred in the city of New York in 1916. The very great care observed by this committee in preparing for the expenditure of the funds raised and the accomplishment of its object represents a good example to be followed in other emergencies of like character.

The report of the committee on out-patient work, by Mr. Michael M. Davis, was in reality an appeal to the association for better administration of dispensaries along the lines suggested by the committee, which had proved to be successful in practical work at the Boston City Dispensary.

A very excellent paper on "Publicity as a Means of Education and Support" was read by Mr. Frederick D. Greene, of the Associated Hospitals of New York. Mr. Greene's advice to the members of the association urging the careful preparation of the statement of the finances of the hospital to be presented to prospective patrons of the institution, so as to be readily understood by anyone, should receive the earnest consideration of every hospital supported by a voluntary contribution. His suggestions relative to information available for the press and public were equally timely.

At the business meeting held after the scientific session on Tuesday afternoon, the recommendations of the board of trustees were considered and referred to the various committees, whose actions were necessary in the preparation of resolutions to be presented, in accordance with the requirements of the constitution and by-laws.

In the absence of the chairman of the committee on health insurance, this report was submitted by Mr. Michael M. Davis, another member of the committee, and its discussion disclosed the fact that most of the members of the association were looking forward with various emotions to the enactment of laws which would be of mutual advantage to the employer and employee and eventually meet the needs of the nation.

In the discussion comment was made on the fact that the state of Ohio had appointed a commission and voted a sum of money sufficient for its needs, to study the situation and report back to the legislature the results of the findings and recommendations for future legislation, which it is hoped, will solve the problem of health insurance for the state of Ohio, and help in its solution for other states having membership in this association. That the deliberations of this committee will be of value to this association is assured by the fact that our first vice-president is one of its members.

Dr. Thomas Howell, superintendent of the New York Hospital, an institution situated in the heart of the industrial district of New York City, read a paper on "The Workmen's Compensation Law and Its Relation to Hospitals," which, if carefully studied and the directions given therein followed, will obviate the usual difficulties that superintendents find in complying with the law. The historical information of this paper, together with the explanation of the workings of the compensation law in the various states, were particularly clear.

The paper of Mr. Pliny O. Clark, Wheeling, W. Va., on "Hospitalism, Its Causes and Treatment," will prove of

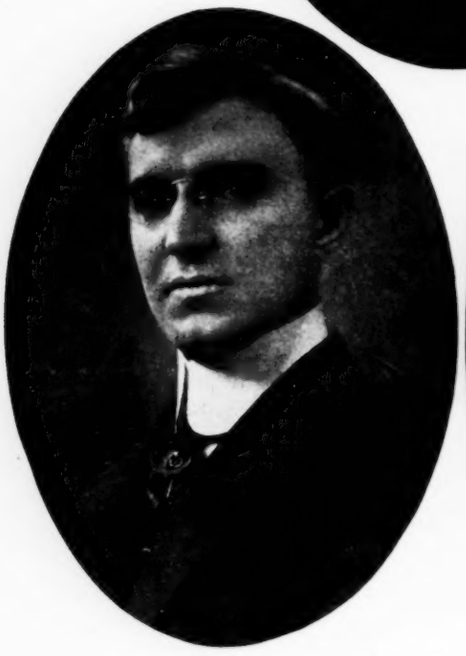
especial value to the members of the association who follow its advice. Mr. Clark attributed hospitalism largely to a lack of proper sociological investigation and medical study, and believes that when hospitals perform their full duty in these matters the evils of this character will be reduced to a minimum.

A paper of unusual interest and the one that seemed to arouse the greatest amount of enthusiasm was that on "The Reorganization of the Civilian Hospital on a War Basis." Read by Major Winford H. Smith, ex-president of this association, now attached to the office of the Surgeon-General of the United States Army, it re-received, as it deserved, the earnest attention of all the members. The words of timely warning of the unprepared condition of most of the hospitals of this country to serve the country as they are expected to do in time of war must be heeded by the members of this association if they are earnestly desirous of doing their full duty to their country.

The paper of Dr. T. N. McEachern, of Vancouver, B. C., on "Annual Reports" brought forth so much general discussion that it was at once evident that the members of the association were fully aware of the meager and frequently useless contents of their reports. The recommendation of the paper that statistical and scientific information be compiled in such a manner as to give a complete review of the hospital for each year ought to commend itself to every member.

The recommendations of Dr. Walter Morritt in his paper on "Practical Hospital Economies," if carried out, are sure to add to the efficiency of any hospital.

The report of the committee on accounting, presented by Dr. A. R. Warner, Lakeside Hospital, Cleveland, Ohio, was received with enthusiasm and adopted by the association. In the discussion that followed the reading of this report, the members of the association generally pledged themselves to follow the procedures recommended in so far as they were able to do so under the laws governing their various institutions.



DR. A. B. ANCKER,
President American Hospital Association
Superintendent St. Paul City and County Hospital, St. Paul, Minn.

DR. WILLIAM H. WALSH,
Secretary,
Philadelphia, Pa.

MR. ASA BACON,
Treasurer,
Superintendent Presbyterian Hospital, Chicago, Ill.

The report of the committee on standardization of hospitals, presented by Dr. W. H. Smith, was in reality a continuation of his morning paper on the subject of the reorganization of the civilian hospital.

Mr. F. E. Chapman, superintendent of Mount Sinai Hospital, Cleveland, Ohio, presented a paper on the

"Equalization of Departments in Accounting," which, if carefully heeded by members of this association in studying the cost of operating and maintaining the various divisions of their hospitals, will certainly lead to lessening of total expenditures and prove the exact relation of departments to each other, in their relative cost and usefulness.

DR. A. R. WARNER,
First Vice-President,
Superintendent Lakeside Hospital,
Cleveland, Ohio.

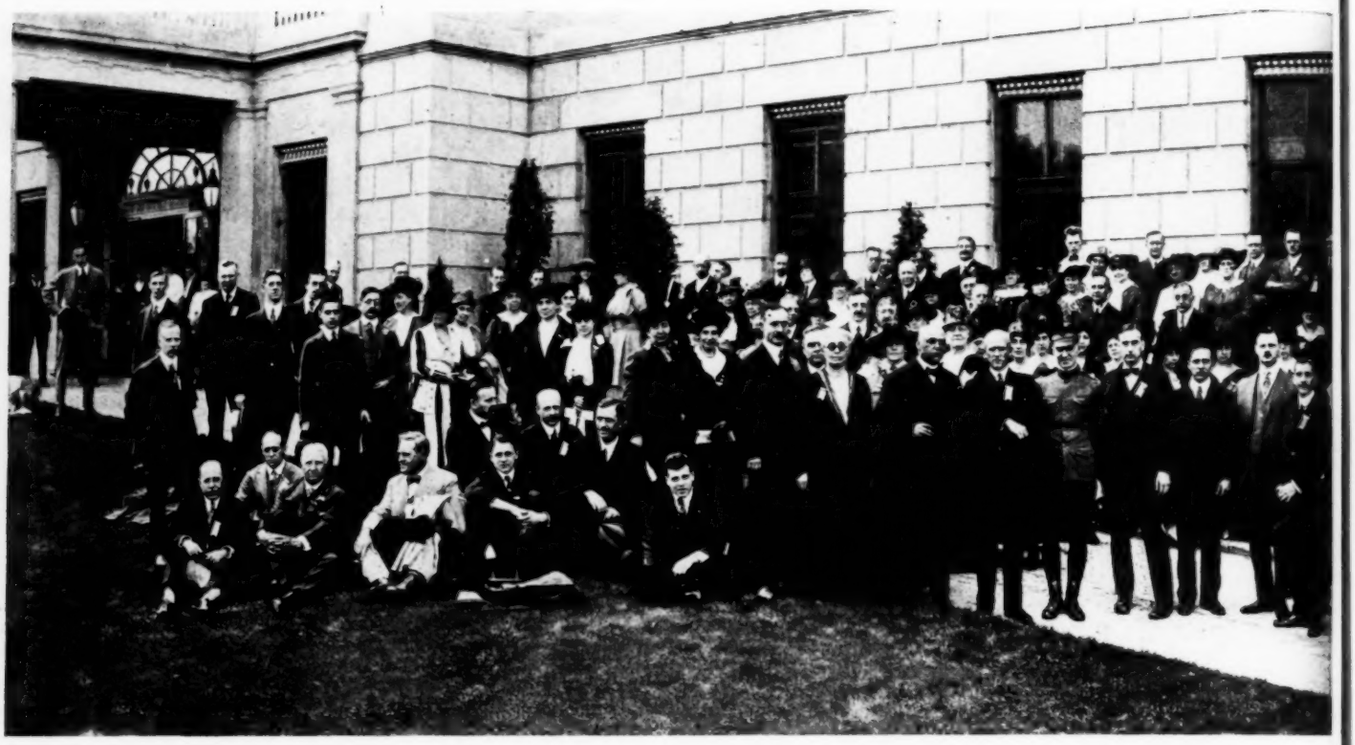
MR. E. S. GILMORE,
Second Vice-President
Superintendent Wesley Memorial Hospital,
Chicago, Ill.

DR. WINFORD H. SMITH,
Trustee,
Superintendent Johns Hopkins Hospital,
Baltimore, Md.

MISS MARY L. KEITH,
Trustee,
Superintendent Rochester General Hospital,
Rochester, N. Y.

Papers were read on "Oil as a Fuel" by Dr. John M. Peters, Providence, R. I.; "The Hospital a Teaching Institution" by Dr. Harold C. Goodwin, Albany, N. Y.; "War Hospitals of France and America"; "The Relations of the Superintendents to Research Work" by Dr. H. O. Collins, Minneapolis; and "Municipal Training Schools" by Dr. Cleveland H. Shutt, St. Louis.

"The Relation of the Superintendent to the Governing Board and Obligation as Admitting Officer," read by Miss Alice C. Cleland, Northampton, Mass., reiterated the necessity of carefully defining the duties of the superintendent in these relations and seeing that he or she is empowered to carry out their provisions. Its discussion also em-



Members of the American Hospital Association on their visit to Mount Sinai

phasized the fact that there are a great many small hospitals in this country which do not carry out even the rudiments of diagnosis on admission, or preserve vital statistics of the slightest degree of value to the country.

Miss Nellie F. Parrish, Mr. Joseph Geffen, and Dr. H. J. Moss also read papers of general interest to the members.

The address of Hon. Alfred T. Fleming, representing Hon. James M. Cox, governor of Ohio, was received with enthusiasm by the association.

The address of Dr. Henry C. King, defining the aims and purposes of the League to Enforce Peace, was also enthusiastically received.

The address of Major Hoover, who has just returned from France, where he was in charge of the medical work of the Lakeside unit, proved of great interest to the association. The first-hand information thus received as to war conditions at the front gave the members of the association some realization of what they may expect to contend with when our own troops are actually engaged in active military duty at the front.

* * * *

Luncheon at Mount Sinai Hospital

A most enjoyable side trip, as a break in the regular convention program, arranged by the local entertainment committee, was an automobile ride, followed by a luncheon at which Mr. Chapman, superintendent of Mount Sinai Hospital, acted as host.

Immediately after the Wednesday morning session the members and visitors were met at the Hollenden Hotel by over 300 machines, which were lent by the public-spirited Cleveland people. The machines were preceded by a squad of motorcycle policemen, and the visitors were driven through the business section and out to Mount Sinai Hospital. A buffet luncheon was served on the lawn, the visitors seating themselves in a circle and being served by nurses. A very appetizing lunch was served, after which the visitors were escorted through the hospital. It is enough to say that Mr. Chapman's efficiency as a superintendent was displayed in the selection and serving of the luncheon. Everybody present seemed to feel his personal magnetism.

After luncheon a group picture was taken of all visitors, and they were again escorted to the machines and taken for a ride through the various parks and the beautiful residential sections of Cleveland and out to the Cooley Farms, which were inspected with a great deal of pleasure. The route selected was chosen by Mr. Alward, of the Simmons Company, and a more ideal selection of streets and beautiful places could not have been chosen.

* * * *

New Officers of the Association

The officers elected by the American Hospital Association for the ensuing year are: Dr. Arthur B. Ancker, superintendent St. Paul City and County Hospital, St. Paul, Minn., president; Dr. A. R. Warner, superintendent Lakeside Hospital, Cleveland, first vice-president; Mr. E. S. Gilmore, superintendent Wesley Hospital, Chicago, second vice-president; Miss Grace Fairley, lady superintendent Alexander Hospital, Montreal, third vice-president; Mr. Asa S. Bacon, superintendent Presbyterian Hospital, Chicago, treasurer; Dr. William H. Walsh, Philadelphia, secretary; Miss Mary L. Keith, superintendent Rochester General Hospital, Rochester, N. Y., trustee.

It was fitting that the Cleveland convention should elect, as its president, one of the most efficient hospital administrators in this country. Dr. Arthur B. Ancker began his hospital career thirty-four years ago in a little makeshift private residence temporarily fitted up as the St. Paul City and County Hospital. His institution has steadily grown in size, in service, and in importance until it is now one of the foremost hospitals of this country, and this in spite of the fact that municipal hospitals as a rule are not con-

Hospital, Cleveland, during the nineteenth annual convention.

sidered among the best institutions that we have. One may wander through the hospitals of this country and every little while he will find some architectural feature or some new method of management or some new piece of equipment which originated in Dr. Ancker's institution.

Dr. Warner's administration of Lakeside Hospital, Cleveland, is one of the bright spots in hospital management of today. Dr. Warner himself has introduced new features in economy and new points in service. He has brought his dietetic department to a high state of perfection. He himself has done more in the perfection of oxygen-nitrous oxid anesthesia than all of the rest of us combined.

Mr. Gilmore, second vice-president, has demonstrated what may be done in a few years with a hospital almost on its last legs. When Mr. Gilmore took charge of Wesley Hospital, Chicago, its financing was wretched, its debts were large, its credit was nil, and its administration and its service to the sick were of the worst. In Mr. Gilmore's administration the debts have all been paid, the hospital has been almost reconstructed, new additions have been made, the scientific departments have been brought up to a point of modern efficiency, large amounts of endowment funds have been given to it, and the hospital today is a prosperous and a most useful institution.

Miss Fairley is Canada's contribution to our official family. She is an able hospital administrator, and her own hospital, under her hands, has become one of the substantial and strong institutions of Canada. Moreover, Canada deserves much at the hands of the American Hospital Association, as she deserves much at the hands of the world. Canada is making a glorious fight for democracy. Her sons are giving their lives by thousands for the principle which we all today are brought to serve, and her hospitals are taking a foremost part in the reeducation, the reconstruction, and the rehabilitation of those who are coming back maimed and crippled and who must make new arrangements for independence and a living. When the story of Canada's hospitals during the war is told it will be a historic and wonderful narrative of patriotism and high purpose. It is little enough that we have done in electing Miss Fairley one of the officers of the association.

There is little that needs to be said about Mr. Bacon; officers come and officers go, but Mr. Bacon is treasurer forever.

The thanks of the hospital world are due to Dr. William H. Walsh for his splendid administration of the association during the past year, and his reelection was, of course, a foregone conclusion. Dr. Walsh has breathed new life into the affairs of the association. He has put the organization on the map, and, although he has been modestly feeling his way for the past year, he has done a tremendous amount not only to serve the association, but also to serve the hospitals of the country.

And now just one word about the trustees: there was a question in the minds of a great many people, when our new constitution was adopted at Philadelphia, whether a partly permanent board of trustees might not be the process for the setting up of an autocracy in the management of the affairs of the association, and by many it was thought better to continue the election of a complete board of trustees each year in order that the association members might always and at any meeting be entirely free to express themselves as to policies and plans for the association.

The past year has demonstrated beyond question that the creation of a board a majority of whose members continue in office from year to year is the wiser plan. Our board of trustees has been conservative yet progressive. Its policies have been safe and sound. The association is in good hands, and because of the wisdom of the board the association is now upon a firmer footing, with hardly a chance for any error or for mismanagement or for false moves.

Miss Mary L. Keith, elected last year for the short term of one year, was reelected at Cleveland for a full three-year term.

* * * *

The Next Meeting

There was a good deal of discussion as to the next meeting place. The committee on time and place, composed of Dr. H. O. Collins, Minneapolis, chairman; and Dr. J. W. Fowler, Louisville, Ky., and Dr. S. A. Sexton, Baltimore, members, were not a unit on the recommendation. Dr. Fowler was anxious for the convention to go to his city, and the other members felt that the next meeting should be held in the East. There were members of the association who favored Washington, because of the war and the importance of having the meeting where the heads of the War and Navy Departments and the Public Health Service could attend. Others felt that, while it was important that the meeting be held near the center of the country's greatest interest, yet Washington itself could easily be so crowded at the meeting time that the association would not be able to hold the attention of the delegates, even if there were hotel accommodations for all.

It was eventually decided to make the choice either Washington or Baltimore, with a majority favoring the latter city. Discretion was left to the board of trustees to choose between the two cities and to fix the precise date.

It was somewhat embarrassing to Dr. Fowler to be a member of the committee, as he was a strong and interested advocate of his own city as the meeting place; he would have been more free to fight for Louisville if he had not been on the committee. This experience will probably lead, in the future, to the naming of a committee none of whose members has a personal interest in any city invitin the association.

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PROGRESS OF THE AMERICAN HOSPITAL ASSOCIATION

Annual Report of the Secretary, Dr. William H. Walsh, Shows Flourishing Condition—Gratifying Range of Activities

As this is the first report submitted to the association by the secretary since the appointment of such an officer was authorized, there will naturally be some departure from the custom of former years. In this report an attempt will be made to review the work of the office during the past year, to comment fully upon the affairs of the organization, and to offer suggestions and recommendatiens for the future.

Although it was distinctly understood at the time of the appointment of the secretary that his full time would not be demanded by the association, it soon became manifest that, in order to do justice to the work confronting him, not only full time would be required, but considerable overtime; consequently for the first seven months practically all of the secretary's time was consumed in perfecting a suitable accounting system, correcting the membership list, outlining plans for development, and attending to the vast amount of correspondence incident to the publication of the 1916 Proceedings, the preliminary plans for the new commercial exhibit, and the Bureau of Information and Registration.

The past year has been one of fruitful progress, and it can be authentically stated that the affairs of the American Hospital Association were never in a more healthful state.

PUBLICITY

Every effort has been made to acquaint the public and more particularly the various allied professions with the objects and aims of the association, and no opportunity has been lost to obtain publicity when it was thought that it would be beneficial. Our current transactions have been listed in the various exchanges, and copies have been sent to the large metropolitan libraries.

The secretary has endeavored to publish bulletins of interest to the membership each month in those periodicals reaching hospital people, wherein the trustees' meetings have been noted and other items concerning the work of the office have been recounted with the hope that such information would stimulate interest in the affairs of the organization. It is too early to form any definite idea as to the value of our bulletins, but we have received many inquiries that can be traced thereto. We also believe that a number of new memberships were secured as a result of this publicity. The secretary wishes to tender his grateful thanks to THE MODERN HOSPITAL, the *Southern Hospital Record,* and the *Trained Nurse and Hospital Review* for the gratuitous space freely offered.

One of the principal sources from which this office hoped to secure valuable information for publication in the form of bulletins was the various committees, and in this connection a letter was addressed to the chairman of each committee, asking for items of interest relating to their special field. It must be frankly stated that there has been little response to this appeal with but a few conspicuous exceptions. The hope is expressed that during the coming year the various committee chairmen will take more interest in this valuable feature.

MEMBERSHIP

A constant effort has been made to increase the membership of the organization, and, although this labor has not shown any remarkable results, it has justified the time and expense incident thereto. Were it not for the ever-present necessity for the conservation of our financial resources, more spectacular results might have been reported. It should also be here noted that the facility of procuring new members is in direct proportion to the benefits offered to prospects, and until such time as *interested* persons can be convinced of the value of membership, it will be somewhat difficult to interest the skeptical.

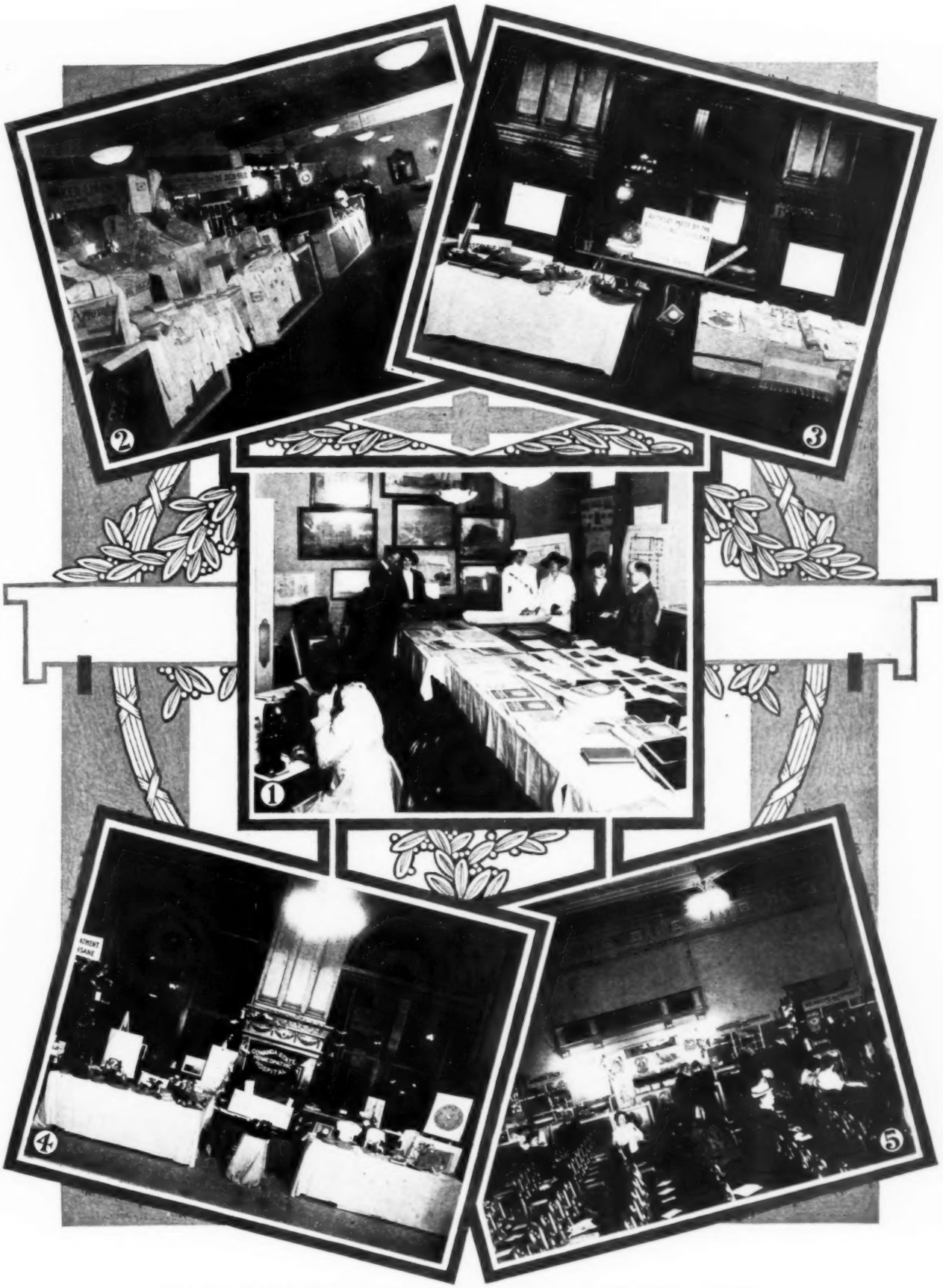
Elsewhere in this report will be outlined a plan for the enlargement of our association by means of a membership campaign, and the attention of all members is urgently directed thereto.

The membership list to date shows the following members in good standing: members, 1,149—active, 870; associate, 264; honorary, 10; life, 5.

The following are the delinquents to whom several bills have been sent with requests for payment. We have never had a reply either in the form of a remittance or a letter. It is improbable that we have the incorrect addresses, because the letters have never been returned: delinquents, 84—active, 59; associate, 33.

It would be quite incorrect to say that the following members have resigned during the past year. A large number replied to our requests for payment of dues with the information that they had sent in letters of resignation previous to the 1916 convention, some in 1914, 1915: resignations, 32—associate, 5; active, 27.

We now have the cards of forty members showing no addresses. The 1916 Proceedings and bills for dues were mailed to these members, but in every case both were returned marked "not at," "removed."



Some of the Exhibits at the Convention of the American Hospital Association

1, "Information Bureau," conducted by THE MODERN HOSPITAL, and showing the exhibit of hospital plans by prominent architects. Here all mail for members and guests was distributed and telephone calls received; 2, a corner of one of the commercial exhibit halls; 3, the noncommercial exhibit of the Cleveland Society for the Blind; 4, the noncommercial exhibit of the New York State Hospital Commission; 5, a view of the meeting hall, showing how some of the commercial exhibits were arranged around the sides of the room.

From September, 1916, to September 1, 1917, 134 new members have registered.

BUREAU OF REGISTRATION AND INFORMATION

The inauguration of the Bureau of Registration and Information has created a very favorable impression, and quite a number of new members were secured through its activity. As funds become available the scope of the work may be enlarged until this feature alone will make membership well worth while. The attention of members is invited to the fact that the bureau cannot be expected to supply nurses, at least for the present. To move a nurse from one part of the country to another in the hope that she will meet the requirements of the vacancy is a very unsatisfactory method of filling such positions, and members are advised to utilize the services of the bureau only when executives or heads of departments are desired. At headquarters a register is maintained upon which are recorded the names and data concerning all applicants, and also the vacancies existing. From this information a constant effort is made to satisfy all of the demands made upon us.

The secretary believes that this is an opportune time to formulate a definite policy with respect to the work of the Bureau of Registration, and with that end in view the office has already refused to supply a qualified superintendent to a hospital that was notoriously mismanaged. While the association has not as yet placed itself upon record as to the standards for a reputable hospital, it does not require such action to determine that certain so-called hospitals are not suitable places for qualified applicants. From experience already recorded it would seem necessary to remind certain institutions that in utilizing the services of our bureau the obligation of fair treatment to the appointee is thereby incurred, and that unless this obligation is fully met, the bureau will not supply a second candidate.

TRANSACTIONS 1916

The publication of the eighteenth annual proceedings was a much greater task than had been anticipated, necessitating, as it did, most voluminous correspondence. One of the greatest obstacles to the early printing of this volume was the neglect of authors to return copy, or even to respond to our inquiries regarding it. Whether or not the failure to respond to ordinary correspondence is a delinquency peculiar to hospital executives I cannot say with surety, but I can make the unreserved statement that our affairs have suffered more during the past year from this evil than from any other handicap.

It has been the invariable rule of this office to respond within twenty-four hours to all communications received, and your secretary believes that this rule has created a most favorable impression upon many who have in former years ofttimes waited a whole month for a reply to an inquiry.

Heretofore it has evidently been the custom to give free of charge a considerable number of the Proceedings. This matter was discussed by the trustees, and as a result the secretary was instructed to print upon the back of each volume the price. It has been found that certain libraries and associations to whom the book had formerly been given free were quite willing to meet the charge.

Much expense and inconvenience has been caused by the failure of members to keep the office notified of changes of address, although it is believed that this may be overcome in 1918 by sending out bills for dues prior to the publication of transactions.

NEW BUSINESS PROCEDURE

At an early meeting of the trustees it was decided to so modify the business procedure as to place most of the routine work in the office of the secretary. In pursuance of this policy the secretary was instructed to formulate a workable plan, and this was later accepted and adopted. All applications for membership are now handled entirely by the secretary, and bills for dues are sent out and collected by him. Funds of the association are deposited to the credit of the association, and once deposited cannot be withdrawn without the signature of both the treasurer and the secretary. When funds are deposited a duplicate deposit slip is forwarded to the treasurer so that he may know exactly the condition of the treasury at all times. By this method the treasurer remains the custodian of the funds, but is relieved of the heavy burden of clerical work heretofore thrust upon him.

The secretary is responsible to the trustees for all expenditures, and, when amounts exceeding one hundred dollars are involved, specific authority is required before the indebtedness is incurred. At each meeting of the trustees a full report is made of all expenditures, together with a review of the work accomplished since the last report.

In revising the accounting system of the association, the gratuitous services of Mr. Cornelius S. Loder were secured. The whole system devised and recommended by this gentleman, although approved by the trustees, has not yet been adopted on account of the expense incident thereto, and for the further reason that it was considered advisable to utilize all the old forms before ordering the new. When the complete system is in operation the business of the association will be greatly facilitated, the funds will be doubly safeguarded, and the work will be much simplified.

In formulating the accounting system now in use, it became necessary to consider the advisability of changing the fiscal year, from one convention to another, from January 1 to December 31. It is realized that a change in the by-laws is necessary to authorize this arrangement, and such an amendment will be offered at this meeting. The new plan will only change the period for which dues are paid and will not in any way increase the assessment. This scheme will simplify the treasurer's annual report, will avoid the congestion at the registration desk during conventions, and will facilitate the work of the secretary's office.

INCORPORATION

The American Hospital Association has never been an incorporated body, but the time has now come when some action in this direction must be taken. As now organized, the trustees are obliged to assume personal responsibility for all the acts of the organization, and, since financial obligations are concerned, it would hardly seem fair to continue this practice. Much study has been given this matter by the trustees, they having carefully considered the laws of various states concerning the incorporation of similar bodies. As the American Hospital Association is a national body and also because of the restrictions found to exist in almost every state, it was definitely decided to recommend that this association be incorporated in the District of Columbia either by special act of Congress or by the courts. Your secretary hopes that favorable action will be taken upon this recommendation, since the advantages are so obvious.

1917 ANNUAL CONVENTION

While this office was busily engaged in perfecting the necessary plans for the nineteenth annual convention and

the commercial exhibit connected therewith, the country was thrown into an unprecedented state of excitement by the declaration of war.

The local committee expressed a desire to postpone the convention, some prospective exhibitors hesitated about incurring new obligations, and a few members wrote intimating that the grave responsibilities incident to the war would prevent their attendance.

From the outset it became evident to the trustees that either to postpone or to omit the convention this year would be a grave blunder, and that the incidence of war only emphasized the necessity for an assemblage of hospital people. The many vital problems concerning interns, hospital staffs, organization of base hospitals, and numerous other similar matters required some authoritative solution, and, after due deliberation, the trustees passed a resolution authorizing the secretary and local committee to proceed with the arrangements and to announce that under no condition would the original date be changed. It is the belief of your secretary that the accomplishments of this convention will prove the wisdom of the trustees' decision.

The program is replete with subjects of deep concern to all the hospitals of the country, and matters of absorbing interest to those who at this time are struggling under many unusual burdens and almost overwhelming handicaps.

It will be noted that the meetings convene at 9 a. m. daily instead of 10 as heretofore. This change permits a more extensive program and makes it possible to schedule business meetings at 4:30 for the conduct of the purely business matters of the association. By this means it is hoped to avoid the confusion incident to past conventions, when scientific papers and business affairs were crowded together.

COMMERCIAL EXHIBIT

The display of hospital supplies and equipment exhibited at Philadelphia was considered by the oldest members of the association to be the most comprehensive ever assembled, and most of the exhibitors themselves were well pleased with the business transacted and the attendance. However, your secretary was far from satisfied, and, as he is compelled to assume the attitude of the manager of a commercial undertaking, he must needs be as critical as the most dissatisfied participant. In the first place, little if any recognition was accorded the commercial exhibit upon our program, which was arranged as though no such important project was contemplated; consequently *no* time was allowed for inspection, compelling those who recognized the value of such inspection to absent themselves from important meetings. In the next place, as might have been expected, some little difficulty was experienced in enforcing certain rules and regulations that were considered necessary for the ethical conduct of a commercial exhibit. With respect to the allowance of certain periods for the inspection of exhibits, it can be said that ample time has been allowed this year, and no complaint is expected upon this score. The rules regarding solicitation of business and the distribution of literature in the convention halls are more definitely understood now and will be rigidly enforced.

One obligation rests upon the members of this association, i. e., that of inspecting every exhibit, and unless all lend their cooperation to that extent, this feature of our convention is doomed to failure. No one is compelled to purchase, for the very good reason that these exhibits are primarily for advertising purposes rather than for sales.

As the report of the treasurer clearly indicates, the financial returns from our last exhibit were very gratifying, and the returns this year will about equal those of 1914.

RECOMMENDATIONS

Policy.—The time has come for this great association, representing as it does the consensus of opinion of the hospital experts of America, to fasten its faith to a few cardinal principles upon which we may hold our ground and maintain before the world an unmistakable attitude.

It is, to say the least, embarrassing for the executive secretary of this association to be compelled to reply to those who seek our counsel and advice that no definite policy has as yet been adopted upon many of the vital questions of the day.

Unless we are to fall by the wayside or delegate our responsibilities to newer and more wideawake organizations, we must meet our obligations fully, placing the American Hospital Association upon record as opposed to those things which we know to be wrong.

First and foremost, we are obliged to announce some attitude upon the question of the abuse of dispensary privilege; then in order the following subjects should be thoroughly discussed and our position defined:

1. Use of first- and second-year student nurses for private work outside hospitals without supervision.
2. Baby farms under the guise of maternity hospitals.
3. Standard course of training for nurses, and obligations of a hospital to the student.
4. Definition of a modern hospital, and a workable classification.
5. Functions of various hospital officials and their limitations: (a) trustees; (b) superintendent; (c) medical and surgical staff; (d) principal of training school.
6. Standard accounting system upon which a basis may be obtained for the comparison of different institutions.

Much could be here written upon the above-mentioned subjects, but it is the belief of your secretary that these matters should be very carefully considered by the association and further studied by a special committee charged with the task of formulating concise recommendations for submission to this body at the twentieth annual convention.

Constitution and By-Laws.—In compliance with the instructions of the trustees, certain modifications in our constitution and by-laws found necessary last year have been compiled and submitted to the committee upon that subject. No attempt has been made in this contemplated revision to make any change in the form of the organization for the reason that many of the foremost members of the association are compelled to be absent by reason of military service abroad. For the same reason it is urged that no fundamental change in our constitution and by-laws be offered at this meeting, as it would be unfair to those absent to deny them a voice in matters in which they are so deeply interested.

War Medical and Nursing Problems.—For the same reason that some of our best hospitals have been driven to the expedient of turning to fourth-year students for interns, hospitals will be obliged to consider the advisability of turning out third-year nurses to meet the community requirements should the war continue for any extended period. Any steps that may be taken tending to lower the standards of the nursing profession will of course be reluctantly considered, but facts must be faced and conditions met by intelligent and timely action.

Unless special means are adopted to add to the supply of nurses there will be no replenishment for three years. The successful waging of the war contemplates the adequate protection of the civilian population from sickness and disease, and this cannot be accomplished effectually

unless those who may justly be regarded as guardians of the public's welfare are constantly reinforced.

From the very moment of the adoption of the draft law, this organization has been hard at work in the endeavor to convince the authorities of the necessity for the exemption of medical students and interns. Early in our efforts we discovered a determined opposition upon the part of the government to the exemption of medical students or interns as a class, for the very good reason that such a ruling would immediately open up the possibility of fraud and misrepresentation. Acting upon a knowledge of this attitude, various methods were suggested for the accomplishment of our effort to prevent the complete disorganization of our civilian hospitals. On August 30 the Provost Marshal General notified the governors of all states of the promulgation by President Woodrow Wilson of supplementary regulations governing the execution of the selective service law with special reference to interns and medical students, as follows:

May Apply for Discharge

First. Hospital interns who are graduates of well-recognized medical schools, or medical students in their fourth, third, or second year in any well-recognized medical school who have not been called by a local board may enlist in the Enlisted Reserve Corps provided for by Section 55 of the national defense act under regulations to be issued by the Surgeon-General, and if they are thereafter called by a local board they must be discharged on proper claim presented, on the ground that they are in the military service of the United States.

Second. A hospital intern who is a graduate of a well-recognized medical school, or a medical student in his fourth, third, or second year in a well-recognized medical school, who has been called for by a local board and physically examined and accepted, and by or in behalf of whom no claim for exemption or discharge is pending, and who has not been ordered to military duty, may apply to the Surgeon-General of the Army to be ordered to report at once to a local board for military duty and thus be inducted into the military service of the United States immediately thereupon to be discharged from the national army for the purpose of enlisting in the Enlisted Reserve Corps of the Medical Department. With every such request must be inclosed a copy of the order of the local board calling him to report for physical examination (Form 103) affidavit evidence of the status of the applicant as a medical student or intern and an engagement to enlist in the Enlisted Reserve Corps of the Medical Department.

Will Not Be Sent to Camp

Upon receipt of such application with the named inclosures, the Surgeon-General will forward the case to the Adjutant-General with his recommendations. Thereupon the Adjutant-General may issue an order to such intern or medical student to report to his local board for military duty on a specified date, in person or by mail or telegraph, as seems most desirable. This order may issue regardless of the person's order of liability for military service. From and after the date so specified, such person shall be in the military service of the United States. He shall not be sent by the local board to a mobilization camp, but shall remain awaiting the orders of the Adjutant-General of the Army. The Adjutant-General may forthwith issue an order discharging such person from the military service for the convenience of the government.

Three official copies of the discharge order should be sent at once by the Adjutant-General to the local board. Upon receipt of these orders the local board should enter the name of the man discharged on Form 164A and forward Form 164A, together with two of the certified copies of the order of discharge, to the mobilization camp, will make the necessary entries to complete Form 164A and will thereupon give the local board credit on its net quota for one drafted man.

National Headquarters.—Those who have followed the work of the association during the past year will fully realize the necessity for the continuation of national headquarters. The necessary funds for the maintenance of an office and a stenographer will be available, and, if the next convention is held in a city providing adequate accommodation for a commercial exhibit, no fear need be entertained for the future from the standpoint of finances. When the association has been incorporated in Washington it would seem desirable to move the offices there, too, and your secretary herewith recommends that such steps be taken as soon as practicable after the adjournment of the convention.

Committee Appointments.—Heretofore no policy has existed with respect to the continuous service of committees, and the various lines of endeavor have suffered thereby. As each incoming president assumed office the entire personnel of committees has changed even though their proceedings were incomplete and the studies unfinished. This method is certainly not conducive to efficiency, and the association has undoubtedly lost much of value by this shortsighted policy, not to mention the loss of interest of those who were so summarily displaced.

It is not often wise nor usually necessary to continue *all* the members of a committee from one year to another, but it is imperative that at least one member of each committee serve for two successive years. It is therefore recommended that in the appointment of the 1917 committees, at least one member be retained to preserve a continuity of effort.

President Elect.—Another improvement in our present methods would be accomplished by the nomination and election of a president elect each year. Many kindred organizations have adopted this plan, and it has worked most successfully. As now organized it is never known until almost the termination of the annual convention who is to become the next president, and as a result of this uncertainty the newly elected incumbent is totally unprepared for the responsibilities of the office, and at best has scanty time to utilize his energies for the benefit of the association. If a president elect were annually installed, the incumbent would have two years to formulate his policy and familiarize himself with the association affairs. Your secretary realizes that this change would necessitate a modification of the by-laws, but considers it of sufficient importance to merit immediate consideration.

SUMMARY

The year 1917 has been marked by the appointment of a secretary, the establishment of a permanent headquarters, and an entire revision of the business methods of the association. Progress has been rapid, and the organization is more widely known than ever before in its history.

Publicity has been constantly sought and bulletins published monthly.

The membership of the association has been slightly increased and few old members lost; the membership list has been revised and tabulated upon a visible index system.

The Bureau of Registration and Information, so long discussed, is now in working order prepared to meet any reasonable demands made upon it. The value and utility of this undertaking will be limited only by the amount of funds available for its maintenance.

The 1916 Proceedings were published in a volume which has received the hearty praise and commendation of a large number of prominent members. It is a book whose contents and appearance make it a most valuable addition to any library. The price of $1.50 has been fixed, at which price it may be purchased from headquarters.

An entire new business and accounting system has been adopted, placing our association in line with the policy so

strongly urged by it for accurate and standardized accounting methods. We are now in a position to close our books at the end of each calendar year, have them properly audited, and publish the report in the current transactions.

In all probability the association will have been incorporated before another year shall have passed. This legal procedure will guarantee us a definite standing in the country, and will enable us to build upon a firmer foundation.

In spite of almost unsurmountable difficulties, the preparations for the 1917 convention were carried to a most successful termination, and an exceedingly interesting and timely program arranged.

The exhibit of hospital supplies and equipment arranged this year is second only to that displayed in Philadelphia. It is regretted that more commodious quarters were not available and that those utilized were not better arranged, but honest effort was made to make the best of adverse conditions.

The estimate placed upon the American Hospital Association in the future will very largely depend upon the early adoption of a policy or standard of ethics which may be used as a guide for those who are honestly striving to improve the hospital situation in America. Our present haphazard course will sooner or later lead us upon the rocks unless a reliable compass is secured to direct us.

Since many of those who always have been with us are today upon the battlefield, the indulgence of those who are enabled to attend the convention this year is asked with respect to any modification of our constitution and by-laws which might be considered radical. The trustees have definitely passed upon this subject, and it is therefore hoped that only such modification will be proposed as will plainly expedite the business methods of the association.

The accounts show a healthy condition, and the funds are in sight to enable us to continue our present organization intact. Many extraordinary expenses had to be met this year in connection with the establishment of headquarters and the purchase of supplies.

The war will undoubtedly necessitate certain changes in long-established standards and customs. The withdrawal of 40,000 nurses from this country will require replacement by some means, and the prospect of turning out at once all third-year nurses is worthy of consideration. Some standards must be lowered and it is for us to discuss at this time the extent to which such modifications shall be carried. The shortage of interns and physicians will likewise require certain changes, one of which is the term of service for interns. Hospitals requiring a longer term than one year will be doing a distinct service to the country by changing the service to one year, particularly since the government will insist upon this as regards drafted men who are exempted.

The association now has a home and can be reached at all hours of the day by local and long-distance telephone. A collection of hospital reports, books of reference and information, price lists, catalogs, etc., are all available to those who pay us a visit. Correspondence is answered promptly and the interests of the organization are under watchful eyes every day in the year.

The complete change in personnel of important committees each year is not considered a wise policy, and is believed to work to the disadvantage of the association. This condition can be remedied by the continuation of one old member on each committee from year to year, so that at least one member shall serve two years.

Your secretary is heartily in favor of increasing the membership by any legitimate means, and is therefore urgently recommending the inauguration of a membership campaign for this purpose.

FINALLY

The administration of the affairs of the American Hospital Association has been a very great pleasure, and the most intense personal satisfaction has been accorded the writer in the accomplishment of every task that has been set before him. Throughout the year the president, officers, and trustees have directed and aided him in every endeavor, and any success that may have resulted is due more largely to their able service and counsel than to his own ability.

It was hoped that it would not be necessary for your secretary to enter the service of the government, but conditions have arisen which have caused the army to call upon all of military age, and the writer did not feel as though he could conscientiously decline to offer his services. Since accepting the present assignment, the business of the association has not suffered, and every spare moment has been devoted to its interests, and your secretary wishes to add the assurance that the association has in no way suffered on account of his assumption of added burdens.

Respectfully submitted,

WILLIAM H. WALSH, Secretary.

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Report of the Board of Trustees of the American Hospital Association, 1917

The board held three regular meetings during the year, and in addition acted upon a number of matters through the medium of the mail.

The individual members have been at all times in close touch with the secretary, so that he has had throughout the year the benefit of this counsel and advice. One additional meeting was called to act upon the matter of the exemption of interns from the selective service law, but, as favorable action was announced prior to the date set for the meeting, it was canceled on account of the close proximity of the date set for the nineteenth annual conference.

The following matters were considered or acted upon at the various meetings:

1. Appointment of secretary.
2. Incorporation of association.
3. District censors.
4. Official organ.
5. Cooperation of the Bureau of Standards and Supplies.
6. Organization of sections.
7. Delegates.
8. Life membership.
9. Accounting system and business procedure.
10. Publication of transactions.
11. Commercial exhibit.
12. Bureau of Information and Registration.
13. Delinquent members.
14. Publicity.
15. Campaigning for new members.

APPOINTMENT OF SECRETARY

At the first meeting of the trustees, careful estimates were made of the cost of maintaining a permanent secretary with headquarters. It was found that the funds were adequate to meet those expenses, and the board therefore, in accordance with the desires of the association, engaged the full time of your secretary, Dr. William H. Walsh, and authorized the rental of a suitable office for headquarters.

The value of this procedure was immediately apparent. The secretary devoted himself to the organization of a real business office, the scope of the association's possible activities became much wider, and the tremendous power for good of the association was made available. It is for the association to name the secretary as one of the most important officers, but the trustees are confident that the members will appreciate the value of a man thoroughly interested in our work and enthusiastic and energetic in following it up.

INCORPORATION

The present trustees have accepted without protest responsibility for the actions of the association, financial and otherwise, but the attention of the membership is invited to the necessity for immediate incorporation. The subject has had the very studied attention of your board, which unanimously agrees that steps should be taken at an early date to incorporate. The laws of various states have been scanned with the object of selecting the one whose laws were most liberal, but it was finally deemed expedient to urge incorporation in the District of Columbia, and we now submit this conclusion as a definite recommendation.

DISTRICT CENSORS

In order to provide further safeguards to prevent the admission of undesirable persons to our membership, it was decided to inaugurate a system of censorship under the auspices of the secretary.

It is the opinion of your board that the appointment of a district censor for each state in the Union, each province of Canada, one for Australia, one for Honolulu, and one for the Philippines will not only serve the purpose indicated, but will create a body of interested members whose interests will also be constantly stimulated by a constant touch with the affairs of the association.

OFFICIAL ORGANIZATION

At the eighteenth annual convention a motion introduced by Mr. R. R. Ross upon the subject of the adoption of THE MODERN HOSPITAL as the official organ of the association was referred to this body for a report at this convention.

Your board must confess that, although the subject has been discussed at each meeting, no decisive conclusions were reached. It is a subject of vital importance and one that, we believe, cannot be decided this year. An official organ would in many ways be extremely advantageous to our association, and yet such a step cannot be taken until some financial arrangement is made regarding the subscription price.

It would be manifestly impossible for the publishers to give the journal free of charge, and on the other hand the dues that are now paid fall far short of supporting the organization. It would seem to your board that until the association decides to increase the annual dues to a figure that will meet the annual expense plus the cost of subscription it would not be wise to offer any definite recommendation.

The board recognizes that the cost of membership in addition to the cost of attendance at meetings is a considerable item for many of our members, and believes it important to encourage both membership and attendance, yet perhaps some method may be devised whereby a considerable proportion of the membership may become subscribing members so that an arrangement may be made with THE MODERN HOSPITAL which shall be mutually advantageous.

BUREAU OF STANDARDS AND SUPPLIES

Recognizing the many advantages of association with a centralized purchasing agency, your board, through its secretary, has approached the New York bureau with the object of learning the extent to which that organization would cooperate with us. Unfortunately, but little progress can be here reported. However, the whole subject of centralized group purchasing is being studied, and, if no further progress is made with the agency already existing, your board will consider the possibility of establishing a more national agency under its own auspices. Our investigations already indicate that the service now rendered by the Bureau of Standards and Supplies to its membership could be made available to all our members at a very small cost.

ORGANIZATION OF SECTIONS

Some confusion has resulted since the adoption of Article VI of the constitution, providing for the establishment of sections. It was hoped that this provision would meet a dual purpose, namely, the organization of affiliated bodies and the division of our program into departments. After due consideration it is now thought best to recommend the elimination from the paragraph of so much thereof as refers to geographic divisions and to provide therein only for divisions for the conduct of scientific business. As the insertion of another article providing for affiliated organization is inseparably linked with the formation of a house of delegates, it is considered unwise to introduce it at this meeting during the absence of so many of our members.

HOUSE OF DELEGATES

We believe that within a few years we shall be enabled so to reorganize the association as to make it a central body composed of state, territorial, and geographic units, but until that time arrives we cannot recommend the formation of such a body. It is our intention to aid and encourage the organization of geographic units throughout this country and Canada in every way possible, and any association of hospitals contemplating such organization will be supplied by us with a copy of standard constitution and by-laws. We shall also be glad to include in the bulletin of the association any items of interest that may be submitted by local associations.

LIFE MEMBERSHIP

When it is considered that the moderate sum of fifty dollars was adopted for life membership, it is a great surprise that more of our members have not grasped the opportunity to enter this class of membership.

It is our opinion that the sum of one hundred dollars should be charged for active life membership and fifty dollars for associate membership. It does not require a mathematician to determine that if every member would now become a life member at $50, the interest on the proceeds would not support the association.

ACCOUNTING SYSTEM AND BUSINESS PROCEDURE

Without charge to the association, an expert accountant has assisted in outlining a more suitable system of accounting than has been heretofore used, and it is hoped that it will be in working order within the near future. The new check book is now in use, and a sum of money transferred to the checking account under the supervision of the treasurer. When the entire new system is working, the treasurer will have been relieved of all routine work, without in any way encroaching upon his responsibility for the safeguarding of the funds.

DESCRIPTION OF SYSTEM

Income.—(a) from dues; (b) from membership lists and other literature, etc.; (c) from the commercial exhibit in connection with the convention (this will occur during a brief period of about six months); (d) disbursements, largely by treasurer from his own outside separate address—including regular payroll, and all bills except small and irregular items; this latter going through the office under a petty cash voucher system. All revenues, irrespective of amount, to be deposited in the selected depository and the treasurer to be advised of the deposit on a regular form and to acknowledge receipt to the office.

THE COURSES AND FORMS RELATING TO DUES

Bill for annual dues: On a 3 by 5 card with name and address on same for use in connection with the "window" envelope (Form A) when bill is received with remittance simply receipt and remail to member in another "window" envelope.

A loose-leaf cash book, in which pages are numbered: Moore system can be used to enter daily any descriptive form of such items (Form B). Then the payment of dues shall be entered on the ledger form of the member paying the dues (Form C).

The payment in check, money order, or cash is then deposited in the bank, and the treasurer is notified, who makes acknowledgment on special form sent him by the office (Form D).

The office shall maintain an independent account of its own—a petty cash account—for small and miscellaneous disbursements, such disbursements to be on a voucher system and give amount maintained. When this amount has been determined, then the treasurer aids in maintaining it on the vouchers received, all of which should be signed by the person receiving the money and the secretary or some one designated by him (Form E).

The purchase order form shall be used for purchases, orders, supplies, etc., and made out in triplicate on the typewriter in one operation. The original (or white sheet) is sent to person of whom goods are ordered; the first carbon copy (or blue sheet) is sent to treasurer as evidence to check with bill when it is received; the second or final carbon copy (or buff sheet) to be retained at the office as evidence and for reference to "check up" when order is filled (Form F).

A weekly and monthly financial statement is to be drawn weekly and monthly by the office on a triplicate typewriter form in one operation. The original copy (or white sheet) is sent to the treasurer; the first carbon copy (or blue sheet) to the president or to finance committee; the second or final carbon copy (or buff sheet) to be retained by the office. This will insure all responsible interests keeping in close and intimate touch. It permits the prompt correction of any error. It allows all to act in closer unison in event of outside criticism, and to assist the secretary in the annual audit, the monthly statement to include all within its period, even supplying weekly records (Form G).

PUBLICATION OF TRANSACTIONS

While the cost of the transactions was somewhat high, your board is satisfied that the quality of the paper, type, and general work are a marked improvement upon previous issues. As had undoubtedly been observed, a number of changes have been adopted which it is hoped will be continued. For instance, instead of printing the constitution and by-laws in the front of the book, these have been placed in the back. The list of previous conventions, with names of past officials, has been rearranged. The title has been so printed on the back as to make it plainly visible when the book is standing upright upon a shelf, and finally the price at which the volume is sold is plainly indicated. The grade of paper selected has very greatly enhanced the value of the book.

It is regretted that the transactions were not published at an earlier date, but many obstacles intervened to delay it. Both the president and the secretary reported difficulty in obtaining replies from members. For this reason the committee appointments were not settled until a late date, and some of the papers, sent to authors for correction and revision, were not received until the transactions went to press.

This year the board has endeavored to anticipate these annoyances by requesting all authors to supply a copy of their papers to the secretary in advance of the convention, and it is our hope that the Nineteenth Annual Transactions will be in the mail by March 1 at the latest.

Another matter concerning the transactions that received our attention was that of the free distribution of extra copies. In our present financial condition it is impossible to distribute these volumes free of charge, and a resolution was therefore adopted directing the secretary to plainly print upon each volume the price of $1.50, and to charge this amount to all who wished to subscribe for it.

COMMERCIAL EXHIBIT

The splendid exhibit displayed at Philadelphia provided the means by which your board was enabled to engage a secretary and maintain national headquarters. It is hoped that every member will fully realize this and in doing so remember that there rests upon each of us a definite obligation to treat the exhibition with fairness. In recognition of the value of these displays, the president has so arranged the program as to allow ample time for all to inspect carefully the many interesting exhibits of hospital supplies and equipment. Every member is earnestly solicited to allot at least one hour to the careful scrutiny of the commercial exhibit.

BUREAU OF INFORMATION AND REGISTRATION

No innovation in the history of the association has been of greater moment to its members than the inauguration of this bureau. Of course, it is only in its infancy, and much remains to be accomplished before the plans formulated will have been consummated, but enough has already been done to assure confidence in the assumption that this service alone will prove an attractive inducement to those contemplating joining the association.

It is the hope and wish of your trustees that there shall be assembled at the national headquarters a comprehensive reference library covering every activity that even remotely affects the hospital world. The collection of hospital reports already listed affords a valuable reference library, and we believe it will be possible and practicable to publish within a few years an annual hospital guide, in which might be correlated all information of interest regarding every hospital in America. The demand for such a book is very great, and its publication by the association would become a source of income.

The registration activities have gradually increased until it became necessary to restrict the work to the registration of executives only, and this restriction will have to continue until our treasury will permit the engagement of more clerical help. Requests have poured in for nurses, interns, engineers, pharmacists, and even laundresses, until the secretary was compelled to report his inability to supply requests. The bureau solicits the cooperation of

every member, not only in making known vacancies, but also in urging those seeking positions to communicate with the office. Superintendents, principals of training schools, dietitians, and housekeepers can usually be supplied upon short notice, but it is always requested that, before accepting an applicant, independent investigations be made in order doubly to assure the responsibility and capability of the applicant. It is clear that the association cannot guarantee the qualifications of either party when it acts as agent, although it will endeavor to list only those who conform with its own high standard.

DELINQUENT MEMBERS

We can conceive of nothing that would cause more surprise to those who methodically pay their dues from year to year than the publication of the list of delinquents. It is difficult to understand why those whose responsibility is unquestioned will ignore every communication regarding dues and deliberately permit themselves to fall in arrears. We believe some method will have to be adopted whereby a penalty shall be assessed when dues fall behind more than one year. To cover this matter, the recommendation is made that a penalty of 10 percent shall be imposed upon all dues remaining unpaid at the termination of the annual convention. This recommendation will be presented in the form of an amendment to the laws.

PUBLICITY

The trustees authorized the secretary to publish in suitable mediums such items of interest to members as might be available. In order to avoid the possibility of any suspicion of favoritism toward any special publication, it was expressly stipulated that such bulletins were to be given out to any respectable journal with sufficient bona fide circulation to warrant the expense entailed. This body has no means at this time of knowing the effect produced by the bulletins that have already appeared, but it is our opinion that a favorable impression has been created. Those matters discussed by the trustees at the various meetings were duly chronicled and those members sufficiently interested were enabled thereby to keep in touch with our proceedings. It is our intention to continue this feature, gradually enlarging its scope and usefulness.

CAMPAIGN FOR NEW MEMBERS

This subject was introduced by the secretary after a strenuous attempt had been made to secure new members by means of letters. To those of us who had seen the abuse of the "whirlwind campaign," the idea of adopting such a plan did not at first make a strong appeal. The matter was considered, however, from every possible angle, until your board became convinced of the feasibility of the plan under proper auspices and subject to such limitations as might be imposed by the board. The secretary was directed to explain the scheme in detail, and it was agreed to submit the project to the association with a favorable recommendation.

The trustees believe that a new era in the work of the association is developing. The meetings of the board have been too few and too short to accomplish all that it seems quite possible to accomplish. Yet it is better to make haste slowly, and the representatives of this widely spread organization must be proportionately widely scattered, so that meetings are costly in time as well as in money. Moreover, many of our people are devoting themselves to the immediate problems of these strenuous times, and men and women who have been among our leaders are giving their time to patriotic service, both at home and abroad, and it is well to await a time when their good counsel can again be fully available and peace shall bring a more confident view of the problems of the future.

The association was a powerful factor in the solving of the problem of the draft of medical students. Some of our leading men devoted themselves to the question, and the cooperation of our representatives all over the country made rapidly possible by our new organization brought the desired results.

Other problems will arise, and the knowledge and experience of the members of this organization should be put to service for the public welfare. We look forward to an important year's work, thanking those who have willingly helped when called, and assured always of hearty aid in all good works in the future.

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Names of Those Who Registered at the Bureau of Information During the Cleveland Meeting

Not all of those who attended the nineteenth convention of the American Hospital Association registered. The following is a list of those who left their names in the Bureau of Information conducted by THE MODERN HOSPITAL:

(A., active; Ap., application; As., associate; E., exhibitor; G., guest; L., life; P., prospective.)

Armstrong, Victoria E..A..City Hosp., Washington, Pa.
Alward, W. L.....E..Simmons Co., Cleveland
Aikens, Charlotte.....G..Detroit
Ashbel, Mrs. Carey....G..Salem
Aarsrud, Gena K.....A..Fairview Hosp., Minneapolis
Agnes, Sister.....G..Charity Hosp., Cleveland
Alderson, Mrs. Dr .....G..Dubuque, Ia.
Alderson, Dr. James...A..Findley Hosp., Dubuque, Ia.
Allen, Miss Bertha W...A..Huron Rd. Hosp., Lowell, Mass.
Anderson, J. K.....G
Applegate, Miss.....E..Gowanda State Hosp., Collins, N. Y.
Armbruster, E. J.....E..Nat. Marking Mach. Co., Cincinnati
Ashton, Miss.....E..Republic Mfg. Co., Cleveland
Anisfield, John.....A..Cleveland
Alicia, Sister.....G..Academy Lady of Lourdes, Youngstown, O.
Altschul, D. S.....A..Bronx Maternity Hosp., New York City
American Laundry
Mach. Co.....E..Cincinnati
Automatic Electric Co...E..Chicago
Ancker, Arthur D.....A..City and County Hosp., St. Paul, Minn.
Anderson, Dr. Albert..A..State Hosp., Raleigh, N. C.
Ayers, N. F.....G..E. W. Marion Co.
Amadus, Sister.....G..Charity Hosp., Cleveland
Agnes, Sister.....G..St. Mary's Hosp., Clarksburg, W. Va.
Avita, Sister.....G..St. John's Hosp., Cleveland
Appel, Katherine.....A..Howard Hosp., Philadelphia

Brown, Miss Ethel L...G..City Hosp., Akron, O.
Bayer, Olive .....G..University Hosp., Kansas City, Mo.
Bassett, Mrs. J. L.....G..General Hosp., New Britain
Bates, F. O.....A..Roper Hosp., Charleston, S. C.
Beers, Miss Mollie.....A..Cambria Hosp., Johnstown, Pa.
Binger, Miss M. L.....A..Woman's Hosp., Detroit, Mich.
Black, Dr. C.....G..Isolation Hosp., Toronto, Ont.
Borden, Richard P.....A..Union Hosp., Fall River, Mass.
Boysen, A. W.....E..Coast Products Co., St. Louis
Brigid, Sister .....A..Charity Hosp., Cleveland
Browning, Miss.....A..St. Clair Hosp., Cleveland
Buse, Miss Alice E.....A..Corry Hosp., Corry, Pa.
Butterfield, C. L.....A..Martin's Ferry Hosp., Martin's Ferry, O.
Bishop, Mrs. H. E....As..Sayre, Pa.
Bolt, Dr. .....Cleveland Hosp. Council
Born, Henry G .....E..Born Steel Range Co., Cleveland
Bostwick, H. J.....As..Clifton Springs Sanatorium, Clifton Springs
Bradley, J. H.....E..Philadelphia
Barnaby, Miss M. D...A..Heywood Memorial Hosp., Gardner, Mass.
Bacon, Asa S.....A..Presbyterian Hosp., Chicago
Bailey, Jr., Geo.....A..Cooper Hosp., Camden, N. J.
Bailey, Miss Sarah H..G..West Chester, Pa.
Baldwin, Dr. L. B.....A..University Hosp., Minneapolis, Minn.
Bates, C. E.....E..Philadelphia
Birtch, F. W.....A..San Francisco
Bishop, H. E.....Robert Packer Hosp., Sayre, Pa.
Beecher, Bertha .....G..Cincinnati
Bond, Chas. R.....E..New York City
Bush, Gertrude.....G..Cleveland
Botdorf, H. E.....G..Stanley Supply Co., New York City
Bonaventura, Sister....G..St. Joseph's Hosp., Pittsburg
Baxter, Edward J.....G..Cleveland
Ball, Dr. Otho F.....L..THE MODERN HOSPITAL, St. Louis
Bunch, Marie .....G..Kansas City, Mo.
Brothertson, Geo. T....E..Philadelphia
Bunn, Fred S.....A..Youngstown Hosp., Youngstown, O.
Becker, Ada .....G..Lima, O.
Bacon, Mrs. Asa.....Presbyterian Hosp., Chicago
Burlingham, Dr. L. H..A..Barnes Hosp., St. Louis

Binkley, Miss .....G..Canton, O.
Buford, Louise .....G..Lucas County Gen. Hosp., Toledo, O.
Bailey, Dr. Wm. L....A..Lakeside Hosp., Cleveland
Bassitt, Geo. B.....A..Buffalo
Baldwin, L. F.....G..Massillon, O.
Baxter, Miss Caroline..G..New York City
Bailey, Dr. Wm. T.....G..Lakeside Hosp., Cleveland
Brooks, Miss A. M.....G..Lakewood, Hosp., Lakewood, O.
Becker, Ray .....G..THE MODERN HOSPITAL, St. Louis
Bauernfeind, Rev. J. H.A..Deaconess Society Hosp., Chicago
Bauernfeind, Howard...G..Deaconess Society Hosp., Chicago
Baxter, Donald E.....A..THE MODERN HOSPITAL, New York City
Butler, Dr. Alice.....G..Cleveland
Butler, Charles .....A..New York City
Behrens, P. W.....A..Toledo Hosp., Toledo, O.

Carmel, Sister .....G..Pittsburg
Chrysostom, Sister.....G..Charity Hosp., Cleveland
Clark, Miss A. F.....G..Lakewood, Hosp., Lakewood, O.
Collins, Mrs. H. O.....G..Minneapolis, Minn.
Collins, Richard.....G..Minneapolis, Minn.
Campbell, Dr. A. D.....G..Glenville Hosp., Cleveland
Clark, Paul L.....G..Huntsburg, O.
Clark, Mrs. L. D.....G..Huntsburg, O.
Cooss, Mrs. W. N.....G
Chapman, F. E.....A..Mount Sinai Hosp., Cleveland
Clementine, Sister.....G..Mercy Hosp., Canton, O.
Carmelita, Sister.....G..Charity Hosp., Cleveland
Columba, Sister .....G..Charity Hosp., Cleveland
Caley, Fred H.....G..Cleveland
Carmody, E. L.....E..Pittsburg
Chapman, W. L.....E..Rutherford, N. J.
Clark, C. R.....E..Providence, R. I.
Collins, Miss Elizabeth..A..Long Branch, N. J.
Cowles, Miss A. B.....A..St. Louis Mat. Hosp., St. Louis
Curry, Miss M. J.....As..Rockford, N. Y.
Camilla, Sister .....A..St. Ann's Hosp., Cleveland
Camp, Dr. F. K.....A..Wesley Hosp., Oklahoma City, Okla.
Camp, Mrs. F. K.....G..Wesley Hosp., Oklahoma City, Okla.
Castelaw, Dr. R. E....A..Kansas City, Mo.
Clark, Pliny O.....A..Ohio Valley Gen. Hosp., Wheeling, W. Va.
Clark, Mrs. P. O.....G..Wheeling, W. Va.
Clark, E. H.....E..Heidbrink Co., Minneapolis, Minn.
Clemo, Irene .....As..Kalamazoo, Mich.
Cleland, Alice C.....A..Cooley-Dickinson Hosp., Northampton, Mass.
Coleman, Miss Laura..A..Homeopathic Hosp., Buffalo, N. Y.
Coleman, Louise.....A..Good Samaritan Hosp., Boston
Colletta, Sister.....A..Charity Hosp., Cleveland
Collins, H. O.....A..City Hosp., Minneapolis, Minn.
Conley, Dr. Walter.....A..Metropolitan Hosp., New York City.
Conn, H. L.....E..Horlick Malted Milk, Racine, Wis.
Cowan, S. H.....E..Stanley Supply Co., New York City
Chappell, Miss Frances.A..St. Luke's Hosp., St. Louis
Crain, Jr., G. D.....As..Hosp. Management, Chicago
Christianson, Miss J.A..A..Northwestern Hosp., Minneapolis, Minn.
Crowell, H. C.....E..Republic Mfg. Co., Cleveland
Cummings, Miss A.....L..C. H. Buhl Hosp., Sharon, Pa.
Crew, E. R.....A..Miami Valley Hosp., Dayton, O.
Cooper, Lenna .....G..Sanitarium, Battle Creek, Mich.
Carter, H. K.....G..THE MODERN HOSPITAL, New York City
Cogan, Dr. J. E.....G..Cleveland

Dikensen, Mrs. E. M...A..Women's Hosp., Detroit
DePeltquestanque,
Estaine .....G..Massillon, O.
Dann, Miss E.....G..Painesville Hosp., Painesville, O.
Dail, Mrs. C. A.....G..Cleveland
Dice, Clara R.....Lakeside Hosp., Cleveland
Day, Miss S. E.....G..City Hosp., Cleveland
DeGolyer, Earl A.....E..Genesee Pure Food, LeRoy, N. Y.
Deaconess Society.....A..Chicago
Dundas, Ethel B.....A..Rochester Gen. Hosp., Rochester, Pa.
Drew, C. A.....A..Wooster City Hosp., Wooster, O.
Dretzka, Dr. L. J.....A..City Receiving Hosp., Detroit
Dorothy, Sister .....G..Charity Hosp., Cleveland
Dolores, Sister.....G..St. Augustine Convent, Cleveland
DesJardins, Clara.....As..New Britain, Conn.
Denton, Emily.....A..General Hosp., Saranac Lake, N. Y.
Davis, Jr., Michael M..A..Boston Dispensary, Boston, Mass.
Davis, Harriett.....A..Cleveland
Davey, A. F.....E..Capital City Dairy Co., Columbus
Darlington, Laura.....A..Johnston-Willis Sanat., Richmond, Va.
Dale, Bessie F.....A..Clymer Miner's Hosp., Dixonville, Pa.
Dakin, Florence .....A..Middletown Hosp., Middletown, O.
Dougherty, Dr. Jno. E..A..Brooklyn
Deaver, Mary F.....As..Cincinnati
Davies, D. H..... ...G..Milwaukee
Dickman, Miss E.....G..Cleveland
Dympna, Sister.....G..St. Joseph's Hosp., Pittsburg
Diack, A. W.....E..Detroit
Donet, Mrs. Elizabeth..As..Memorial Hospital, Mt. Pleasant, Pa.
Dolores, Sister.....Lourdes Academy, Youngstown, O.

Ericson, F. H.....E..Chicago
Emerson, Miss Stella..E..Genesee Pure Food Co., LeRoy, N. Y.
Everston, Jos. H.....E..Chicago
Everingham, Arvill A...A..Rome, N. J.
Eitel, Mrs. Geo. B.....A..Eitel Hosp., Minneapolis, Minn.
Erickson, Carl A.....G..Chicago
Eisen Co., Wm. M.....E..New York City
Ethelrite, Sister.....G..Charity Hosp., Cleveland
Eileen, Sister.....G..St. John's Hosp., Cleveland
Echols, Miss M. C.....G..City Hosp., Massillon, O.
Essig, Anna K.....A..Coatesville Hosp., Coatesville, Pa.
Evelyn, Sister.....St. Elizabeth Hosp., Youngstown, O.

Franz, A. J.....A..Presbyterian-German Hosp., Cleveland
Friedman, Nina D.,
R. N. .....A..Chicago
Fowler, Dr. J. W.....A..City Hosp., Louisville
Ford Co., J. B.....E..Wyandotte, Mich.

Fisher, Dr. Alex.....A..General Hosp., Calgary, Alberta
Fuller, Blanche M.....A..Omaha, Neb.
Frost, M. E.....A..Detroit
Fritschel, H. L.....A..Milwaukee
Friedman, C. A.....G..Chicago
Foy, Mrs. M. S.....A..Battle Creek Sanit., Battle Creek, Mich.
Fowler, B. M.....A..Vassar Bros. Hosp., Poughkeepsie, N. Y.
Ford, Clarence E.....Ap..New York City
Fisher, F. N.....E..Chicago
Fesler, Paul H.....Ap..Oklahoma City, Okla.
Fesler, Mrs. Paul H...G..Oklahoma City, Okla.
Fengel, S. S.....G
Faust, A. L.....E..Nat. Marking Mach. Co., Cincinnati
Fidelis, Sister.....G..Charity Hosp., Cleveland
Floyd, Miss .....G..Cleveland
Ford, A. L.....A..Children's Hosp., Pittsburg
Fleming, Blanche K....A..Grove City Hosp., Grove City, Pa.
Fedeloa, Sister.....G..Charity Hosp., Cleveland
Franz, Olga.....G..E. 55th Street Hosp., Cleveland
Friend, Harriet S. P...G..St. Luke's Hosp., Cleveland
Francina, Sister.....G..St. Ann's Hosp., Cleveland

Graves, Lulu G.....G..Lakeside Hosp., Cleveland
Gibson, Anna L.....As..Huntington Hosp., Boston
Griffin, Rev. M. F.....A..St. Elizabeth's Hosp., Youngstown, O.
Gonzaga, Sister.....G..St. John's Hosp., Cleveland, O.
Giffen, E. C.....A..Wellesley Hosp., Toronto, Can.
Garrison, Charlotte....A..City Sanatorium, Kalamazoo, Mich.
Goodman, Miss M.....A..Boston
Gailey, Miss I. M.....A..Conemaugh Valley Hosp., Johnstown, Pa.
Gary, Mrs. I. C.....G..Chicago
Gary, Dr. I. C.....A..Chicago
Genevieve, Sister.....A..St. Elizabeth's Hosp., Youngstown, O.
Geraldine, Sister.....As..St. Elizabeth's Hosp., Youngstown, O.
Gervasey, Sister Mary..A..Hamilton, O.
Giles, Sister .....A..Charity Hosp., Kansas City, Mo.
Gill, Mrs. C. A.....G..Germantown, Pa.
Gill, Chas. A.....A..Germantown Hosp., Germantown, Pa.
Gothson, Dorothea.....A..Swedish Hosp., Brooklyn
Gilmore, E. S.....A..Wesley Memorial Hosp., Chicago
Goodman, Dr. M. C....A..Cleveland
Golder, Louise.....A..Bethesda Hosp., Cincinnati
Goodwin, H. C.....A..Albany Hosp., Albany, N. Y.
Grace, Sister.....A..Mercy Hosp., Hamilton, O.
Greene, Fred'k D.....As..Associated Hosps., New York City.
Green, Mrs. Almida C..G..Warren Hosp., Warren, Minn.
Gutwald, Katherine....A..Columbus, O.
Gwyer, Frederick.....A..Lincoln Hosp., New York City
Galleri, Elizabeth A....A..Reading, Pa.
Geffen, Mrs. Jos.....A..Mt. Sinai Hosp., Philadelphia
Glidden, R. A.....E..Beverly, Mass.
Gottesman, O. M.....E..New York City
Goodkind, S. B.....G..Toledo, O.
Gilberta, Sister.....St. Elizabeth's Hosp., Youngstown, O.

Hamilton, Mrs. S.....G..Detroit
Howell, Thos. .....A..New York Hosp., New York City
Hildreth, C. B.....A..St. Luke's Hosp., Cleveland
Howell, Chas S.....G..Formerly West Penn. Hosp., Pittsburg
Howell, Maud .....A..Mary Lanning Hosp., Hastings, Neb.
Herrick, Dr. F. C.....G..Hosp. Council, Cleveland
Hubbard, M. C.....A..Ohio Valley Gen. Hosp., Wheeling, W. Va.
Hall, F. W.....E..New York City
Hughes, Albert M.....E..New York City
Hiper, Mrs. Gustave A..G..Milwaukee
Henderson, John T....A..Grace Hosp., Cleveland
Harrison, M.....A..Hamot Hosp., Erie, Pa.
Halverson, Josephine..Pr..Port Huron Hosp., Port Huron, Mich.
Hamill, Nellie R.....A..Hosp. of the Good Shepherd, Syracuse, N. Y.
Hamilton, Dr. S.....A..Harbor Hosp., Detroit
Hartry, Miss H.....A..St. Barnabas Hosp., Minneapolis, Minn.
Hawley, C. J.....E..Hammond, Ind.
Haworth, E. P.....A..The Willows, Kansas City, Mo.
Heard, Thos. H.....A..Victoria Hosp., London, Can.
Heard, Mrs. J.....G..London, Can.
Hefferman, M. J.....E..Hospital Management, Columbus, O.
Hemingway, Miss.....A..Aultman Hosp., Canton, O.
Herbst, S. B.....E..Albert Pick & Co., Chicago
Herman, Sister.....A..Cleveland
Hirschfield, Dr. A.....Pr..Hosp. Com. Bd. Char. & Cor., Minneapolis
Hoeppner, Mrs. E. H..A..Dansville, N. Y.
Hoffman, Rev. Fr.....G..German Hosp., Cleveland
Hofseth, Miss A.,
R. N. .....A..Maple Crest Sanat., Whitelaw, Wis.
Hogle, Miss C. C.....A..Huron Road Hosp., Cleveland
Hornsby, Dr. John A...L..THE MODERN HOSPITAL, Chicago
Hortense, Sister.....G..St. Elizabeth's Hosp., Youngstown, O.
Hilker, F. C.....A..St. Johns Riverside Hosp., Yonkers, N. Y.
Hunt, N. E., R. N.....A..Ellwood City Hosp., Ellwood City, Pa.
Hunter, Miss J. A.....A..Grace Hosp., New Haven, Conn.
Hankins, Mrs. Bert....E..Massillon, O.
Hart, W. O.....A..Presbyterian Hosp., New Orleans, La.
Hayes, G. C.....E..New Jersey
Hayser, Mrs. W. D....A..Long Branch, N. J.
Heinreich, E. F.....E..Pittsburg
Henessey, Berthold....A..Jewish Hosp., Philadelphia
Holstrom, F.....E..Chicago
Hope, Miss M.....A..Babies' Dispensary, Cleveland
Hamilton, Alfreda....As..Protestant Hosp., Columbus, O.
Hatfield, C. F.....G..St. Louis
Hite, Mrs. Edward....G..Martin's Ferry, O.

Irene, Sister.....G..Cleveland
Ivory, Margaret.....A..Windber, Pa.
Isabel Sister.....A..Charity Hosp., Cleveland

Jones, Rev. S. R.....As..Willard Parker Hosp., New York City
Jamison, Mary.....A..Grant Hosp., Columbus, O.
Jones, Miss J. L.....A..South Side Hosp., Pittsburg
Joseph, Mother.....G..Ottumwa, Ia.
Jeffrey, Miss A. T.....A..St. Christopher's Hosp., Philadelphia

Justina, Sister.....A..Charity Hosp., Cleveland
Johnston, Maud L.....A..Homeopathic Hosp., Rochester, N. Y.
Jackson, Mary C.....A..Graham Hosp., Keokuk, Ia.
Jones, M. F.....E..Buffalo Co-op. Stove Co., Buffalo, N. Y.
Johnson, J. E.....E..Am. Laundry Mach. Co., Cincinnati
Jones, M. .....G..Institute Service Bureau, Battle Creek, Mich.
Jennings, Mrs. .....G..Cleveland

Klausner, Alexander...E..Thorner Bros., New York City
Knapp, Miss M. M., R. N. .....A..Overlook Hosp., Summit, N. J.
Kienle, Rev. C. A.....A..Emergency Hosp., Mansfield, O.
Kearney, John R.....E..Sanitary Specialties Co., Cleveland
Klunder, S. E.....G..Chicago
Keith, Mary L.....A..Rochester Gen. Hosp., Rochester, N. Y.
Kobylanski, J. F.....As..Cleveland
Keller, Lydia H.....A..Butte Deaconess Hosp., Butte, Mont.
Kippen, Miss A.....A..Albert Lea Hosp., Albert Lea, Minn.
Kraemer, Miss Elin....A..F. F. Thompson Hosp., Canandaigua, N. Y.

Leck, Harriet.....As..Grace Hosp., Detroit, Mich.
Lyons, Josephine.....G..Lima, O.
Lawrence, Sister.....
Larkins, Frances.....A..New York City
Lightner, J. E.....G..Plainsville Hosp., Plainsville, O.
LeBland, C. H.....A..Charity Hosp., Cleveland
Leggett, Margaret.....A..Bellefonte Hosp., Bellefonte, Pa.
Lewis, A. M.....A..Wichita Hosp., Wichita, Kan.
Linduff, Cora .....A..Dennison, O.
Lawson, Miss M. A...A..City Hosp., Akron, O.
Lindif, Frances J.....G..Green Point Hosp., Brooklyn
Lake, Amzi .....A..Masonic Home, Burlington, N. J.
Larsen, Lutie B., R. N....Decorah Hosp., Decorah, Ia.
Lee, Sarah A.....G..Chicago
Leichofer .....A..German Hosp., Cleveland
Leitch, Jenny.....G..Toronto, Can.
Lewis, Mary E.....As..German Hosp., Chicago
Loder, C. S.....As..30 Church St., New York City
Lohman, A. G.....A..Deaconess Hosp. (German) Cincinnati
Long, Miss E. J.....A..Mercer, Pa.
Loveland, F. A.....A..Corry Hosp., Corry, Pa.
Ludy, Mary B.....A..German Lutheran Hosp., Sioux City, Ia.
Lewis Manufacturing Co. .....E..Walpole, Mass.
Lyon, E. H.....E..Life Saving Devices Co., Chicago
Lynn, H. R.....E..East Cleveland
Lutz, B. M.....Gi..Shenango Valley Hosp., New Castle, Pa.
LeFebvre, Miss T. H...A..City Hosp., Binghamton, N. Y.
Lauman, Anna.....A..Lutheran Hosp., Ft. Wayne, Ind.

MacAdams, Mrs. L. C..G..Cincinnati
MacLaren, Duncan.....E..Powell & Giberson Linen Co., New York Cy.
MacLeod, Dr. N. M....A..Newport Hosp., Newport, R. I.
MacDonald, Mrs. J. J...G..Jersey City, N. J.
MacDonald, Miss C....A..Maternity Hosp., Cleveland
MacEachern, M. T....A..Vancouver Gen. Hosp., Vancouver, B. C.
McPhee, E. L.....G..Henry Ford Hosp., Detroit
McKisson, E. I.....E..Toledo, O.
McLaughlin, Anna.....A..Painesville Hosp., Painesville, O.
McKenna, Mary C.....A..St. Francis Infirmary, Charleston, S. C.
McMillan, Miss.....G..City Hosp., Lockport, N. Y.
McDill, Sister .....G..West Park, Pittsburg, Pa.
McArthur, Miss.....A..General Hosp., Stratford, Can.
McCarthy, A. W.....G..New York City
McConnell, Miss A....As..Roper Hosp., Charleston, W. Va.
McCullough, E. Grace...A..Peter Bent Brigham Hosp., Boston
McDonald, Dr.....A..Jersey City
McDonald, Mrs.....A..Jersey City
McElderry, Miss G. D..A..Hackley Hosp., Muskegon, Mich.
McGrath, Catherine C...G..Surgical Dept. Grace Hosp., Detroit
McKee, Gertrude D....A..Children's Hosp., Milwaukee
McLaren, Margaret....A..Emergency Hosp., Warren, Pa.
Mateer, Margaret B...A..Lima Hosp., Lima, O.
Maggi, M. Bell.....Pr..Barberton Citizens' Hosp., Barberton, O.
Mariam, Sister.....G..Mercy Hosp., Canton, O.
Mackinney, Lydia.....A..Shenango Valley Hosp., New Castle, Pa.
Margaret, Sister.....G..Charity Hosp., Cleveland
Matheson, Jessie.....G..Brockton, Mass.
Metropolitan Hospital Supply Co.....E..New York City
Morrison, H. D.....E..New Castle, Pa.
Miller, Elizabeth F....A..Polyclinic Hosp., Philadelphia
Mitchell, A. H.....E..Philadelphia
Morris, M. .....E..New York City
Morritt, Walter.....A..Colorado Springs, Colo.
Moss, Dr. H. J.....A..Hebrew Hosp., Baltimore
Mace, Miss F.....A..Welland County Hosp., Ontario, Can.
Musgrave, Dr. W. E...A..Children's Hosp., San Francisco
Mauney, J. H.....A..Lincoln Memorial Hosp., Knoxville, Tenn.
Marshall, Mary E.....G..Battle Creek, Mich.
Martin, Miss C. L.....A..Columbia Hosp., Milwaukee
Massey, Dr. V. E.....G..General Hosp., Knoxville, Tenn.
Middleton, Mary A....A..Philadelphia
Miller, Elizabeth .....A..General Hosp., Dover, N. J.
Millman, Bessie M.....A..Orange Memorial Hosp., Orange, N. J.
Milne, Mrs. T.....A..Welland County Gen. Hosp., Ontario, Can.
Mitchell, Miss A.....G..Albany, N. Y.
Moore, Lucy M.....A..Knickerbocker Hosp., New York City
Moore, Mrs. Helen Despelder .....A..City Hosp., Jackson, Mich.
Morgart, Sarah M.....A..Indiana Hosp., Indiana, Pa.
Morrow, Jos. R.....As..Bergen County Isolation Hosp., Oradell, N. J.
Mohler, Dr. H. K.....A..Jefferson Hosp., Philadelphia
Monagle, A. C.....E..Franco-American Food Co., Jersey City
Moulder, J. McLean...A..Bethany Methodist Hosp., Kansas City, Kan.
Moyer, Katherine.....A..Pottstown Hosp., Pottstown, Pa.
Mueller, Vincez.....As..THE MODERN HOSPITAL, Chicago
Murphy, Miss C., R .N..A..Toledo, O.
Mauss, Bessie H.....A..Wellsville Hosp., Wellsville, N. Y.
Metzenbaum, Dr. M...G..768 Rose Bldg., Cleveland
Mott, C. S.....G..THE MODERN HOSPITAL, Chicago

Massecar, Miss .....G..City Hosp., Cleveland
Marthan, Esther.....G..Painesville, O.

Nye, Judge C. H.....A..Painesville, O.
Neer, Dorothy.....G..Robinwood Hosp., Toledo, O.
Napier, Mrs. S. J.....A..City Hosp., Springfield, O.
Nealley, W. G.....A..Brooklyn Hosp., Brooklyn
Nesbitt, Dr. E. M....As..Detroit
Nord, Sister .....G..Chicago
Newman, W. Maud....A..Sewickley Valley Hosp., Sewickley, Pa.
Nealey, C. E.....E..Cleveland
Noback, Gustave J....G..Chicago

Owsley, E. F.....As..Youngstown, O.
Ordway, Clarence S...A..East Side Hosp., Toledo, O.
Olsen, Dr. E. T.....A..Englewood Hosp., Chicago
Olmstead, Dr. Theo....A..Merritt Hosp., Oakland, Cal.
Oberholtz, Miss.....As..Allentown Hosp., Allentown, Pa.
Ohlman, Margaret....As..Wilkesbarre, Pa.
Oberg, C. I.....A..Sherman Hosp., Elgin, Ill.
Overstreet, Miss C.....G.."Hospital Management," Chicago
Olson, Sister .....G..Deaconess Home and Hosp., Chicago
Osborn, Madge G.....G..Cleveland

Patronilla, Sister.....G..Charity Hosp., Cleveland
Patrick, Mother.....G..Our Lady of Lourdes Academy, Cleveland
Patricia, Sister.....G..Charity Hosp., Cleveland
Patton, Miss Arvilla...A..New Brighton, Pa.
Page, Dr. Henry F....A..German Hosp., Philadelphia
Paul, Dr. L. J.....G..City Hosp., Cleveland
Payne, R. A.....E..New York City
Peters, John M.....A..Rhode Island Hosp., Providence, R. I.
Phillips, M. L.....A..Burlington Hosp., Burlington, Ia.
Phillips, Mrs. G. E....G..Detroit
Phillips, Geo. E.....A..Municipal Hospital, Detroit
Portras, Sister.....A..Hamilton, O.
Pratt, M. R.....A..University Hosp., University, Va.
Purcell, Sister.....A..Superior, Toledo, O.
Packard, Dr. S. B.....A..Brockton Hosp., Brockton, Mass.
Peck, Miss C. B.....A..General Hosp., Ashtabula, O.
Pine, Miss Emily.....A..R. S. Frost Hosp., Chelsea, Mass.
Purvis, Joseph.....A..West Suburban Hosp., Oak Park, Ill.
Pound, Clara B.....A..Reid Memorial Hosp., Richmond, Ind.
Potts, Florence.....A..Children's Hosp., Toronto, Can.
Parker, Harriet.....A..Kensington Hosp., Philadelphia
Peskind, Dr. A.....E. 55th Street Hosp., Cleveland
Parrish, N. F.....A..City Hosp., E. Liverpool, O.
Pace, Eva .....G..Cleveland
Palmer, Mrs. M. E....G..Eddy Road Hosp., Cleveland
Prindiville, K. M.....A..Jos. Lawrence Hosp., New London, Conn.
Pringle, J. A.....A..City Hosp., St. Louis
Parker, Dr. G. A.....A..Pottsville, Pa.
Peterson, B. W.....A..Ohio Valley Gen. Hosp., Wheeling, W. Va.

Quayle, Dr. .....G..Cleveland

Raquat, Caroline.....G..Bedford, O.
Rosenberg, Ethelyn....G..Cleveland
Rockwood, Dr. H. L...G..Warrensville Sanatorium, Warrensville, O.
Russell, Miss M. M....G..Cincinnati
Rosemary, Sister.....G..St. John's Hosp., Cleveland
Rayeur, Katherine.....G..Med. Medicochi, Philadelphia
Rogers, Margaret.....A..Jewish Hospital, St. Louis
Rothwell, Katherine....A..City Hosp., Winston-Salem, N. C.
Read, O. R.....E..Read Mach. Co., York, Pa.
Read, Mrs. O. R.....
Reardon, Elizabeth.....A..Ohio Valley Gen. Hosp., McKee's Rocks, Pa.
Robertson, Dr. John...E..Jaeckh Mfg. Co., Cincinnati
Randles, C. R.....E..Randles Mfg. Co., Ogdensburg, N. Y.
Ransom, John E.....A..Central Free Dispensary, Chicago
Ransom, Marie H.....G..Social Service Cent. Free Dispensary, Chicago
Reardon, J. B.....E..Republic Mfg. Co., Cleveland
Robbins, Miss E. E....A..Batavia Hosp., Batavia, N. Y.
Robertson, Marie.....A..Jones Memorial Hosp., Jamestown, N. Y.
Roettger, Frederick....G..Wheeling, W. Va.
Romano, Sister.....A..St. Joseph's Hosp., Kansas City, Mo.
Rosenthal, Arthur.....E..Grand Rapids, Mich.
Riddle, Mary M.....A..Newton Hosp., Newton, Mass.
Rush, N. J.....E..Cincinnati
Raphael, H. .....E..New York City
Roberts, Dr. R. J.....G..New York City
Roth, Mrs. J. E.....G..East End, Pittsburg
Rothschild, Leo.....E..New York City
Russell, C. N.....E..Borden's Malted Milk, New York City

Shepard, Linnie.....G..Lima, O.
Smith, Major Winford A. .....A..Johns Hopkins Hosp., Baltimore
Spitzer, Mrs. Carl.....G..Toledo, O.
Spies, Miss .....G..Painesville, O.
Stevens, Edw. F.....As..Architect, Boston
Smoot, J. M.....E..Pickens & Co., New York City
Scotland, Miss .....G..Grove City, Pa.
Smith, Wm. O.....E..New York City
Smith, Frances.....A..St. Luke's Hospital, Duluth, Minn.
Smith, Miss.....E..Cleveland
Surbray, Mary E.....A..Warren Hosp., Warren, O.
Schfies, Marie .....G..Cleveland
Stair, Blanch.....A..Eddy Road Hosp., Cleveland
Smythe, Miss E.....G..Women's Hosp., Cleveland
Simmon .....E..Cleveland
Siebrandt, J. R.....E..Kansas City, Mo.
Schmid, N. M.....E..Jas. H. Matthews Co., Pittsburg
Smith, Dr. Appleton W. .....A..Hartford, Conn.
Schill, Anna M.....A..Hurley Hosp., Flint, Mich.
Schweder, Miss J. E...G..Bethesda Hosp., St. Louis
Scott, Kathleen.....A..Sparrow Hosp., Lansing, Mich.
Shaeffer, Mary.....G..Easton, Pa.
Shaeffer, Sister.....G..Easton, Pa.
Schoenhen, Marie M...G..St. Louis

Schulz, T. M.....A..Milwaukee County Hosp., Wauwatosa, Wis.
Sexton, Dr. Louis A...A..Hartford Hosp., Hartford, Conn.
Siebert, Emma D.,
R. N.....A..Emanuel Hosp., Mankato, Minn.
Sinclair, Geo. Wm.....A..Winnipeg, Manitoba
Singer, Samuel .....G..New York City.
Shattengren, Sister.....A..Bethesda Hosp., St. Paul, Minn.
Slayton, Ethelyn.....G..Minneapolis, Minn.
Smith, Mary A.....A..York Hosp. and Disp., York, Pa.
Stanislaus, Sister.....G..Wheeling Hosp., Wheeling, W. Va.
Stober, Geo. W.....E..Columbus, O.
Storck, Mrs. H. D.....A..Women's Hosp., Buffalo
Strasser, C. Eugene....A..Jewish Hosp., Brooklyn
Sullivan, Rose B.....G..Detroit, Mich.
Shalvogle, J. J.....As..Pittsburg
Schwidetzky, Oscar
O. R. .....E..Rutherford, N. Y.
Smith, J. M.....A..Muhlenberg Hosp., Plainfield, N. J.
Stone, Mary .....A..Hackensack Hosp., Hackensack, N. J.
Stone, Mrs. .....G..Syracuse, N. Y.
Spalding, J. D.....G..Cleveland
Swarthout, Mrs. Edith..G..Wellsville Hosp., Wellsville, N. Y.
Snyder, Grace.....G..Massillon, O.
Sawyer, C. E.....A..Marion, O.
Skinner, J. O.....A..Columbia Hosp. for Women, Washington, D. C.
Shutt, C. H.....A..City Hosp. Commissioner, St. Louis
Stueber, Dr. F. G.....G..City Hosp., Lima, O.
Stimpson, W. D.....G..U. S. Public Health Service, Washington, D. C.
Salexandrive, Sister....G..Charity Hosp., Cleveland
Steinmetz, Rose K.....A..Children's Hosp., Akron, O.
Sterns, Mrs. W. G.....G..Cleveland
Southmayd .....E..Ohio State Dept. of Health, Cleveland

Toomey, John.....A..Mt. Sinai Hosp., Cleveland
Taylor, G. W.....G..Painsville, O.
Thatcher, Alice.....A..Cincinnati
Test, Daniel D.....A..Pennsylvania Hosp., Philadelphia
Towslee, Dr. L. G.....A..Cleveland
Towns, Chas. B.....A..Chas. B. Towns Hosp., New York City
Trafford, Mary C.....A..Kalamazoo, Mich.
Thoma, Eugene G.....E..New York City
Tinsley, Esther J.....A..Pittston Hosp., Pittston, Pa.
Templeton, Nell J.....A..Salem Hosp., Salem, O.
Thomas, Miss A.....G..Rochester, N. Y.

Underwood, W. B.....E..Rochester, N. Y.

Van Slyke, Dr. E.....A..Women's Hosp., New York City
Viehdorfer, Alma M...A..Allentown Hosp., Allentown, Pa.
Veruke, D. J.....E..Grand Rapids, Mich.

Wilson, Caroline M....A..Supt. Franklin Hospital, Franklin, Pa.
Wagner, Lucca K.....A..Homeopathic Hosp., Reading, Pa.
Waldman, Henry J.....A..New York, N. Y.
Webster, H. E.....A..Royal Victoria Hosp., Montreal, Can.
Weber, J. J.....As..New York, N. Y.
Warner, Regina.....G..St. Gabriel Hosp., Little Falls, Minn.
Widmer, W. A.....E..J. B. Lippincott Co., Philadelphia
Whiting, Dr. A. D.....A..Philadelphia
Woodbury, Dr. W. E..A..New York, N. Y.
Walker, L. C.....E..New York, N. Y.
Walsh, Capt. Wm. H.....Secy. A. H. A., Philadelphia
Weber, Fred.....A..German Deaconess Home and Hosp., Chicago
Weinberger, T.....E..New York, N. Y.
Weisenbach, Leo.....E..New York, N. Y.
Weintraub, G. Z.....E..Cleveland
Wilson, Dr. R. J.....A..New York, N. Y.
Wolcotte, Grace S.....A..Waterbury Hosp., Waterbury, Conn.
White, Regina.....A..Milwaukee
Wright, Elizabeth.....A..Rockford Hosp., Rockford, Ill.
Wright, Howell.....A..Cleveland
Weber, Geo. T.....A..Olney Sanatorium, Olney, Ill.
Weber, Bernard.....G..Olney, Ill.
Warner, Dr. A. R.....A..Lakeside Hosp., Cleveland
Weaver, Olive M.....A..Home and Hosp., Findlay, O.
Weber, Mary.....G..Hastings, Neb.
Wilson, W. B.....A..Rainbow Hosp., Cleveland, O.
Wilkes, P. C.....A..Memorial Hosp., Memphis, Tenn.
Wait, J. Eurs.....G..Superior, Superior, Neb.
Wahlstrom, M.....A..Y. M. C. A., Cleveland
Woodhouse, Miss M. P..G..St. Luke's Hosp., Cleveland
Waschura, Miss Mary..G..St. Ann's Hosp., Cleveland
Wirts, Stephen M.....E..Wolverine Mfg. Co., Detroit
Wood, A. L.....G..Henry Ford Hosp., Detroit

Yengsta, Edith E.....A..Carlisle Hosp., Carlisle, Pa.
Younglove, Anna.....A..Elyria, O.
Yoke, Mary R.....E..Canton, O.
Young, Chas. H.....A..N. Y. Pres. Hosp., New York City

Dr. J. L. Eaton, who has recently assumed the duties of superintendent at State Hospital No. 4, Farmington, Mo., is inaugurating a policy of giving close attention to the physical as well as mental welfare of those under his care. Dr. Eaton started out by ordering larger quantities and a better quality of food for the 700 patients of the institution, who, he believes, were not being properly fed.

Contract was awarded at Girard, Kan., in September, for the erection of a community hospital.

The Establishment of a Department of Preventive Medicine in a Hospital Treating Children

Charles V. Dorwarth, M. D. (Arch. Pediat., 1917, XXXIV, No. 3), says that a hospital treating infants and children is not fulfilling its obligations if it takes care of them only when ill. A department of preventive medicine is just as rightfully a distinct unit of the hospital as the ward, the dispensary, or the pathological department. It should have a medical director at its head, with as many assistants as the work requires; interns assigned to it in rotation; and pupil nurses detailed to receive instruction in medicosociological work. Some of the important functions of such a department would be the establishment of a health clinic, a prenatal clinic, a social service department, a division of physical development, neighborhood educational work, a wet-nurse directory, etc.

The health clinic is a consultation where mothers may bring well children for examination and advice as to means for keeping them well. To this clinic will be referred children discharged from the wards and dispensaries, technically "cured," but with subnormal nutrition and lowered resistance; and there the problem of each individual child is studied and suggestions are given for bringing the child's general physical condition up to the highest efficiency. The health clinic's function should cover prophylaxis against such diseases as smallpox, whooping cough, and typhoid. The regular children's dispensary is too busy with sick children to give any attention to those apparently well; hence the necessity of the health clinic.

The prenatal clinic and the maternity out-patient service would be in charge of an obstetrician. There pregnant women would receive instructions in personal hygiene, a careful history being taken and a complete physical examination made; the patient should be kept under observation and referred to the proper dispensary for treatment of abnormal symptoms if any develop. Patients may be delivered at their homes by the intern to the department of preventive medicine, assisted by the nurse assigned to this department, under the supervision of the obstetrician in charge. A complete examination should be made two or three weeks after confinement for the discovery and repair of any injury incurred during parturition.

The chief function of the social service department is keeping former patients well and out of the hospital. The personnel may include teachers, lecturers, voluntary workers, clerks, clinical assistants, and dietitians. The work of the follow-up nurse is most important; she will visit the homes of patients, explain to the mother the physician's orders, and obtain data with regard to disease-producing conditions in the patient's environment. Convalescent care and summer outings will be provided by this department. The division of physical development should be in charge of a competent teacher of physical education. A gymnasium to give the subnormal a firmer muscular development may be among the activities of this division.

Among the miscellaneous work of the department of preventive medicine may be lectures on infant hygiene for parents, lectures on personal hygiene for expectant mothers, classes in infant care and hygiene for little girls, a club for boys to be trained as a neighborhood sanitary police force, detection by field workers of unlicensed baby farms, efforts to change the environment of children whose parents or guardians are unfit.

Miss Ann C. Barry has resigned the position of night superintendent at the Good Samaritan Hospital, Lebanon, Pa., to take up Red Cross work in Orange, N. J.

THE WAR: ITS HOSPITAL, MEDICAL AND NURSING ASPECTS

THE WAR PROGRAM OF THE UNITED STATES PUBLIC HEALTH SERVICE

Sanitation of Extra-Cantonment Zones—Demonstrations in Rural Sanitation—Various Forms of Cooperation With State Health Agencies—Bill for the Creation of a Sanitary Reserve

The work of the United States Public Health Service has assumed new importance and taken on several interesting phases due to the war. As a preliminary to more detailed accounts of some of this work, the following brief summary from the surgeon-general's office, under the signature of Assistant Surgeon-General W. C. Rucker, will be of interest:

"At the present time the work of the service is largely concentrated on the sanitation of the extra-cantonment zones, this work being performed in cooperation with state and local health authorities. Officers have been detailed to the communities and territory in immediate contiguity with military camps, and intensive health campaigns for the eradication of typhoid fever, malaria, dysentery, and other communicable diseases have been inaugurated. You can readily understand that, next to the sanitation of the camps themselves, this work is most important, as the soldier is fully as liable to contract disease outside of his camp as within. At all cantonments where this work has been instituted, the state health authorities have been advised with and are rendering valuable assistance; the same remark applies to the local health agencies. This phase of our work would of course make a story in itself.

"The demonstrations in rural sanitation work, which has now been considerably curtailed on account of the war, are conducted upon request of state health agencies.

"Other lines along which we are struggling in cooperation with state health agencies and for which they should receive as much credit as ourselves are the reporting of the incidence of disease, the determination of the quality of all water used on interstate carriers, in order to safeguard the health of the traveling public, and studies of the organization of municipal and state health bodies. The work of holding examinations for the selection of competent district and municipal health officers is really along this line. For example, California desired to obtain her district health officers from the United States at large, and we not only conducted the examinations therefor throughout the country, but also judged of the qualifications of the respective candidates.

"I am enclosing a copy of a bill recently introduced for the creation of a Sanitary Reserve. The enactment of this legislation will go far toward bringing about even closer cooperation between Federal and local health agencies than now exists, although I am of the opinion that this cooperative effort was never, in the history of the country, on a more satisfactory basis than at the present time."

JOINT RESOLUTION TO ESTABLISH A RESERVE OF THE PUBLIC HEALTH SERVICE

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, that for the purpose of securing a reserve for duty in the Public Health Service in time of national emergency there shall be organized, under the direction of the Secretary of the Treasury, under such rules and regulations as the President shall prescribe, a reserve of the Public Health Service. The President alone shall be authorized to appoint and commission as officers in the said reserve such citizens as, upon examination prescribed by the President, shall be found physically, mentally, and morally qualified to hold such commissions, and said commissions shall be in force for a period of five years, unless sooner terminated in the discretion of the President, but commission in said reserve shall not exempt the holder from military or naval service. Said officers shall consist of sanitarians, senior assistant sanitarians, and assistant sanitarians, and when ordered to active duty in the service of the United States shall receive the rank, pay, allowances, and leaves of absence of surgeons, passed assistant surgeons, and assistant surgeons, respectively.

SEC. 2. That for the purpose of carrying out the provisions of this act the sum of $300,000 be appropriated out of any money in the United States Treasury not otherwise appropriated.

Passed the Senate June 18, 1917.

Attest: JAMES M. BAKER, Secretary.

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THE REHABILITATION OF WOUNDED CANADIAN SOLDIERS*

Work of the Military Hospitals Commission of Canada in Restoring Functions of Injured Soldiers

[Continued from September issue.]

ORTHOPEDIC WORK

The Military Hospitals Commission decided to center its orthopedic work at one or possibly later on two or three centers. For the present the only orthopedic hospital is that at North Toronto, where a newly constructed Salvation Army training school was taken over, remodeled and considerably added to. It was decided to concentrate the work with this class of patients because of the desirability of having them treated by the very best of orthopedic specialists, such as are not to be found in every small town. Furthermore, a great deal of expensive equipment is required, and it was deemed unwise to have too great duplication of this.

In connection with the purely medical work of the orthopedic home, functional training is carried on by psychological and physiological specialists of the University of Toronto, in Hart House, a special building set aside for that purpose. Apparatus accomplishing the same end by the same scientific methods as the Amar apparatus of France has been devised by the directors of this work, and wonderful results have been achieved. Some effort has been made to have the Canadian Government adopt the Amar apparatus, but as the same work was already being done, there was no necessity. The use of the Amar apparatus begins as soon as the patient comes out from the anesthetic, whereas in Canada it is many months before the reeducation experts ever see the patient, and naturally this circumstance alters the needs to a very great extent.

The work of reeducation, as carried on by these University of Toronto men, began as purely research work in the psychological laboratory, where such marvelously successful results were achieved that the commission decided to back up the workers in enlarging their field until all Canadian soldiers in need of the treatment could receive its benefits. Efforts are being made now to assemble at Hart House every person in Canada known to have the

*This article has been prepared under the auspices of the Military Hospitals Commission of Canada in response to a request from THE MODERN HOSPITAL.

scientific knowledge necessary to carry on this work, and it may be mentioned that the number is not large.

In a brief contribution to the *University Monthly* Dr. E. A. Bott describes the ideals of his work while it was still in the laboratory stage. Appended is his article. It may be added that the commission is sending Dr. Bott to Europe to study conditions there.

REEDUCATIONAL WORK FOR SOLDIERS*

BY EDWARD A. BOTT, Department of Psychology, University of Toronto.

During the past session a special phase of voluntary war work has been undertaken by members of the University staff in the faculty of arts. The term "reeducational," in this connection, is distinct from "vocational" in that the standpoint of the former is therapeutical rather than industrial. It is an attempt, through the use of special methods applied in the period of convalescence normal certain types of physical and mental disability. The treatment referred to is also distinct from, and supplementary to, the regular medical attendance furnished at convalescent hospitals and homes, and has been undertaken through the cooperation of Dr. Goldwin Howland and other medical practitioners now in charge of returned soldiers. Suitable cases for reeducational treatment are at present referred to the University from clinic, in local military hospitals, where they regularly receive massages, and in addition the majority of such cases are attending one or more vocational classes.

The principle underlying reeducational work is to put within a patient's reach the proper apparatus, assistance, and encouragement for practicing such physical movements, or mental processes as may have been interfered with or have entirely disappeared through injury or shock. Individual attention is the keynote throughout, each case being a study in itself. In commencing treatment a detailed survey of the patient's present capacity of actual performance is first undertaken, to ascertain what functions are intact in whole or in part, that may serve as a foundation in working back to normal. An individual instructor then gives his attention exclusively to a given case, and apparatus appropriate to the condition is devised and constructed. There are several advantages of this arrangement as supplementary to the electrical and manual massage regularly given at military hospitals. Mechanical appliances need not be expensive to be effective, but they contribute toward restoration of movement and control by eliciting through a precise task that most essential factor, the patient's own concentrated effort. The coordination of a partially paralyzed arm, for instance, improves more rapidly by driving a nail, catching a ball, whittling a stick, or threading a needle, than simply by having the lame joints flexed. Each man practices daily a variety of exercises suitable to his condition, and once a week is tested upon a number of typical performances. The careful measurement and recording of accomplishment, the interest aroused through individual sympathetic assistance, the sight of others' success, and the ambition to outgrow his own special apparatus, have served to increase the rate of progress of most cases, and to arouse others from a pardonable state of depression which had previously prohibited improvement.

For example, a difficult case of hysterical paralysis of both legs, in a well-knit young man of 22, was recommended in January, 1917. There was a history of burial under sand-bags in April, 1916, without visible injury. A suspected local injury in the spine was not substantiated, and in addition to electrical treatment, hypnotism had been used in England without permanent improvement. On coming to the university he could walk with great difficulty with the use of a cane, hitching the legs forward by movements of the body. He could not step over an inch stick, or raise either foot from the ground. He could not displace a football that was one inch from his toe, or put out either limb to save himself from falling. Any pro-

Courtesy of the Johns Hopkins Nurses' Alumnae Magazine.

St. John Ambulance Brigade Hospital, Etaples, France, which normally accommodates 540 beds. Referred to in Mr. Butler's article, "The Rockefeller Institute War Demonstration Hospital," August issue, page 79.

*Reprinted from The University of Toronto Monthly, April, 1917.

longed attempt to step forward would presently precipitate a most violent shaking of the limb. He thought he had ceased to improve, and was deeply depressed. After attending for two weeks his point of view changed—he resolved he could improve. Within three months he has regained sufficient control to discard his cane, to walk about fairly easily, to mark time, to step over hurdles four inches high, and to kick a tethered football across the room at a target a yard above the floor. His spirits have vastly improved, and the prognosis is for full recovery.

The treatment of distinctively psychological symptoms is more difficult than most cases of paralysis, but is meeting with success, although improvement is usually less rapid. The cases of this sort include loss of speech, temporary partial blindness, disturbances of memory and association, and very frequently in "shock" cases an inability to concentrate upon the simplest tasks, this being marked by a high susceptibility to fatigue, and to brief periods of "confusion." It is found that discouragement and depression often have deepened into obsession regarding the impossibility of improvement, owing to supposed conditions or causes that have no basis in fact. The principles described above, namely, active employment and measurement of such processes as are found intact, are also used in these cases, the first requisite being to cultivate a favorable attitude in the patient.

The work was originally begun last fall, in a more or less experimental way, at the College Street Military Hospital. Two men were treated there daily in the open wards, and made sufficient progress to warrant the continuance of the work upon a larger scale. The accommodation, however, in all military hospitals being already overtaxed, space was offered by Prof. W. G. Smith in a lecture room of the psychological laboratory in the main building. With the approval of Dr. Howland and other doctors in charge, a class was formed to treat men at the university daily, except Saturday, from 4 to 5 p. m. During the Michaelmas term three men who were able to walk from the College Street Hospital attended. At the opening of the new year it was decided to increase the number of selected patients to six, and it has since grown to nine. Additional members of the staff to the number of ten gave freely of their time to instruct men at special hours, and a daily service by private motors was arranged for soldiers unable to walk. The apparatus has now overflowed the original room into three others.

Sixteen cases have been handled in all. Of these, one who learned first to creep and then to walk since August, 1916, is now practically normal at the time of discharge. Unfortunately, three have been discharged from the service while convalescing satisfactorily, and have had to discontinue treatment in order to look for such work as they were able to do. Two patients have been absent some time through recent accidents, and one from sickness. In two further cases, apparatus has been supplied to men at the hospital, in order to enable them to treat themselves. It is, in fact, a chief object of reeducational treatment to encourage and instruct the men to treat themselves. One case only has been discontinued for lack of progress.

In an account of what the university reeducational work is doing there should be a place for acknowledgment of help from certain persons whose interest has made it possible. The incentive to commence such treatment in Toronto as war work is due to the suggestion, encouragement, and personal instruction of Dr. Shepherd Ivory Franz, psychologist at the Government Hospital, Washington, D. C., whose pioneer work in the reeducation of demented paralytics is attracting wide attention in the medical profession. It is desired, further, to thank Professor Mavor for his assistance in commencing a fund for this work. Mr. Currelly and Mr. Graham Campbell have facilitated the building of appliances in their university workshops, and thereby contributed materially to making the work a success. Mr. Campbell has also raised sufficient funds for the present term, the generosity of numerous subscribers having made it possible to purchase or construct the necessary equipment. Acknowledgment, too, is made of the cooperation of those citizens of Toronto who, through all weathers, have maintained a regular motor service between the hospitals and the university, also of the unsparing energy of Mr. H. K. Gordon, who, in acting as secretary, has coordinated and intensified different aspects of the work.

[To be continued.]

NOTES ON BRITISH MILITARY MEDICAL ARRANGEMENTS

Work in the Restoration and Reeducation of Disabled Soldiers—Treatment of Cases of Heart Disease

[By a Retired Army Surgeon.]

MILITARY ORTHOPEDIC HOSPITALS

On account of the magnitude of the present war and its long continuance, also from the serious nature of so many of the cases of wounded, the number of men disabled, either permanently or for a considerable period, has already far exceeded any previous experiences in this country. A large proportion of these men come under the head of orthopedic cases; that is, injuries to bones, joints, ligaments, and nerves, which are capable of treatment, and for which treatment may be applied that will enable the sufferer to earn a living to a greater or less extent. This treatment should be applied as early as possible, and great efforts have been made throughout the country to bring this about.

The chief hospital in England for such cases is that at Rochampton, where (as far back as March, 1916) 1,628 amputation cases had been admitted, and 932 discharged with properly fitted limbs; there was also a waiting list of 2,027, and about 300 fresh cases were being notified each month. Lieut.-Colonel Robert Jones, lecturer on Orthopedic Surgery in the University of Liverpool, was appointed inspector of military orthopedics; he exercises a general supervision over the treatment of such cases in military hospitals throughout the kingdom. One of the first of such hospitals to be established was that at Hammersmith (in the west of London), in the buildings of the infirmary and workhouse. The number accommodated was 800, and in addition to the ordinary surgical treatment, departments for massage and mechanotherapeutics, electrical treatment, radiant heat and various forms of baths were provided; also a gymnasium. There are also large workshops on the premises, where all kinds of special apparatus and appliances can be produced. The staff, besides four surgeons, includes physicians in charge of massage, electrical and balneological departments, an x-ray operator, a gymnasium instructor, and four resident medical officers.

The Pavilion Military Hospital at Brighton, formerly used for the treatment of sick and wounded Canadian soldiers, is now allotted to the English wounded, and in two divisions, comprising 610 beds, are accommodated patients who have lost one or more limbs, and who are suffering from chronic conditions (for instance, necrosis, with discharging sinuses), which render their sojourn in an ordinary hospital impracticable. These chronic cases do extremely well in the invigorating air of Brighton, and, when sufficiently advanced towards recovery, they are transferred to Queen Mary's Auxiliary Hospital, at Rochampton, to have the necessary artificial limb or surgical appliance provided. During their stay in hospital the men are taught various trades and handicrafts.

Her Majesty the Queen presented to this hospital an establishment, fully equipped and in working order, known as Queen Mary's Workshop, where various trades and useful occupations are taught to the limbless soldiers. There are four departments: (1) in the motor department the men are taught the driving, mechanism, repair, and general management of motor vehicles; with such knowledge in his possession a man, though partially crippled, may be able to earn quite good wages, either as repairer or as chauffeur; (2) in the electrical department they are taught the construction and working of electrical ma-

chines and apparatus, electric lighting appliances, electric bells, telephones, etc.; (3) in the carpentry and woodwork shops they learn the essentials of these handicrafts; and (4) in the educational classes, bookkeeping, shorthand, typewriting, etc., are taught. It is stated that men who have gone through one or another of these training courses have always succeeded in obtaining employment without difficulty.

At Tipperary is a large depot for the treatment of men of Irish regiments, who have returned home from war service, and who in a great number of cases need treatment for the effects of wounds. Massage, passive movements, various forms of electrical treatment (galvanic, faradic, ionization, etc.), Swedish exercises for special groups of muscles, and various kinds of baths are among the remedial measures employed. The men are also taught various handicrafts. Down to last August about 10 percent of the cases admitted had been returned to their regiments fit for general duty, about 20 percent fit for garrison duty at home (many of whom subsequently became fit for service abroad), about 12 percent were invalided out of the service, and about 50 percent of the admissions were still under treatment.

An interesting experiment was carried out at the Heritage Craft Schools at Chailey, in Sussex, where for many years crippled children have been educated and taught various handicrafts. Wounded soldiers similarly crippled were admitted to this institution, and to each of them was allotted one of the crippled children as an attendant, or "orderly," from whom the elder sufferer might learn how to adapt himself to the restrictions of his maimed, but not helpless, condition. It was found that the men soon became interested in the occupations of the place, the chief industry practiced being woodcraft, with some farming and gardening.

The care and training of disabled soldiers and sailors after discharge from the service has been carefully considered by the local committee established in Birmingham to deal with this question. A register of all such cases has been compiled and is being maintained. A continuance of hospital, or at any rate, institutional treatment, is in many cases necessary for prolonged periods. For the city of Birmingham (which, with a population of 868,000, is the largest city in England, after the metropolis) the General Hospital, the Queen's Hospital, and the Royal Orthopedic, the Eye, Ear and Throat, the Skin, the Lock, and the Dental Hospitals, have been brought into a combined scheme for such a continuance of treatment of the disabled as may be necessary. For amputation cases requiring further treatment, the First Southern General Hospital and the Dudley Road Military Hospital are available. For cases of blindness the St. Dunstan's Hospital, in the Regent's Park, London, is at present relied on; it remains to be seen if its accommodation will be sufficient.

In regard to the important general question of the provision of accommodation and treatment for men permanently incapacitated, the idea at first entertained by the Central Pensions Committee, that the existing civil hospitals throughout the country should be asked to take in such cases, according to their available number of beds, has, we understand, been abandoned. It would obviously be impracticable on any extensive scale, for the civil hospital provision that exists has been gradually built up to supply the needs of the civil community, and in most cases is not more than sufficient for this purpose; any permanent accommodation for those incapacitated by war must be in addition, and should be provided and maintained on a different basis.

MANAGEMENT OF CASES OF HEART AFFECTION

A piece of valuable research has been carried out at the Hampstead Military Hospital on heart affections in soldiers, with especial reference to the condition known as "irritable heart," frequently also called "soldier's heart," from its common occurrence in the young adult called upon to perform a considerable amount of strenuous bodily work, such as marching with a full kit and arms. It is similar to the affection called, in the official Nomenclature of Disease, "disordered action of heart;" this organ may be irregular in its rate, or in its rhythm, or in both rate and rhythm. The observations apply to 251 cases. Of this nummer 113 were discharged from the army as unfit for service, within a few weeks of their admission to the special hospital. These grave cases comprised 31 cases of mitral stenosis, 7 cases of mitral stenosis combined with aortic disease, 22 cases of aortic disease alone, and 53 cases of disease of the myocardium, either with or without enlargement, and either with or without mitral incompetence. The physical signs to which little value is attached by the Hampstead observers are: (1) extrasystolic or respiratory irregularity; (2) accelerated action; (3) diffusion of impulse; (4) jerky impulse; (5) short, soft systolic apex murmur; (6) systolic murmurs in the aortic or pulmonic region. In this first sifting of the cases, from 35 to 40 percent are discharged as unfit for service. In the second sifting, which applies to 60 to 65 percent of the original admissions, the patients are mostly those with "irritable heart," but some 10 percent are eventually returned as "organic" cases, leaving 55 percent as patients who have *symptoms*, but in whom no trustworthy *sign* of organic heart mischief can be detected, either at the first examination or subsequently. These are the cases on which difference of opinion as to fitness is likely to arise, and a series of test exercises was devised (mostly familiar to the men and the drill instructors, as routine physical drill), supplemented by route marches with light and with full kit. After much work on pulse rate, blood pressure, and respiratory ratio, with instrumental records, and stethoscopic examination, the authors came to the conclusion that a man's *observed* capacity to accomplish work of a given order is the only reliable test for such capacity, and that, after the first sifting, which eliminates manifest organic heart disease, exercises alone serve the purpose of determining fitness for duty. The physical sign to which most value is attached is the rate at which the pulse falls after it has been accelerated by a brief exercise; if a man walk smartly down a flight of twenty steps, along a short corridor, and up the same flight of steps, and the pulse does not return to its original level within two minutes, he will rarely reach a high-grade exercise, but quick recovery of pulse rate is no criterion of ultimate fitness. Men who improve with the exercises and can do route marching are passed, either (a) to duty, or (b) to light duty, and likely to be fit for service overseas in three months. Those who do not come up to these standards, and whose progress is slow, are passed either (c) for light duty, and not likely to be fit for overseas within three months, or requiring special medical treatment; or (d) for service at home. The respective percentages among 138 cases of "irritable heart" in these categories were: 18, 23, 6, and 17 percent; the "permanently unfit" were 36 percent. In 19 percent of the cases of "irritable heart" there was a history of rheumatism or chorea. The chief conclusion arrived at in this important research is that in classifying patients into permanently unfit, and those fit for duty in the four categories just mentioned, "a system of graduated exercises is the only reliable means at our disposal, when patients with

clear signs of serious heart affections have been eliminated, and such a system is also of distinct therapeutic value." The importance of the matter from a hospital administration standpoint is obvious; especially where demand for accommodation is considerable, continuous, and sometimes urgent. It is stated that the average sojourn of "irritable heart" cases in hospital had been three and a half months; under this method of sorting out at Hempstead the average stay has been two months only.

[To be continued.]

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Chicago to Have Reconstruction Hospital

Plans are under way for the building in Chicago of a great "reconstruction hospital," with at least 3,000 beds and with vocational schools in connection. One of these plans contemplates the state's taking over, either by purchase or condemnation, the old Cub baseball park and the erection of a hospital 600 feet long by 125 feet wide and eight stories high, to hold 3,000 wounded. This would be turned over to the War Department, and at the close of the war would be turned back to the University of Illinois as a teaching hospital in connection with the state medical school.

Another alternative would make use of existing facilities. Trustees of Wesley Hospital and Charles Deering have agreed to turn over to the War Department the entire block between Twenty-fourth and Twenty-fifth streets, bounded by State and Dearborn streets, the present hospital to be enlarged to cover the entire block. Also overtures have been made to the trustees of Northwestern University to obtain possession of the full block on Dearborn street, directly west from the present hospital, for the building of a great vocational training school.

Dr. P. H. Magnuson recently left for Montreal, Toronto, Quebec, and Winnipeg, where he will make a close study of the "reconstruction hospitals" maintained in those cities by the British government. It is planned to follow those hospitals and vocational schools, which have been highly successful, as closely as possible.

Upon his return in two weeks Dr. Magnuson will make a detailed report, which will be submitted to the State Council for Defense for consideration. The latter body plans to cooperate directly with the War Department in the matter. Major E. G. Brackett, M. R. C., who has charge of the government hospital plans, is expected in Chicago in a short time to look over the two suggested sites.

Preliminary to the work on the hospital, it is planned that a questionnaire be sent to all employers in the state, asking what forms of employment they can give to men who have sustained various injuries in battle. From this it can be determined what lines of employment should be specialized upon, and this also would afford a means of employment for the vocational school graduates.

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Work of the Ohio Council of National Defense

A new special committee of the Ohio Council of National Defense, devoted to health, hospitals, and nursing, has been appointed by Governor Cox. In brief, the functions of this committee are the following: to work out for the Ohio council a state program on health, hospitals, and nursing; to bring existing health agencies in closer relation to the Ohio council and to the state departments; to make plans for the safeguarding of the health of the civilian population with particular reference to the health of workers employed in the manufacture of war materials; to gather information for the council relative to hospital facilities for the care of returned injured and convalescent soldiers; and to recommend plans to increase the number of graduate and pupil nurses both for public health and hospital service.

The membership of the committee is as follows: chairman, Dr. R. H. Bishop, Jr., health commissioner of the City of Cleveland; secretary, Mr. Howell Wright, Anisfield Building, Cleveland, executive secretary of Cleveland Hospital Council; Mr. Fred S. Bunn, superintendent of Youngstown City Hospital, president of the Ohio Hospital Association; Miss Mary M. Roberts, superintendent of Holmes Private Hospital, Cincinnati, member of nurses' examining committee, State Medical Board; Mr. Robert G. Paterson, 141 E. State Street, Columbus, executive secretary of the Ohio Society for the Prevention of Tuberculosis; Dr. C. D. Selby, Spitzer Building, Toledo, member of the medical section, State Committee of National Defense, and secretary of the Ohio State Medical Association; Dr. George D. Lummis, chairman of the Public Health Council, State Department of Health; Rev. Bernard P. O'Reilly, St. Mary's College, Dayton, O.

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The Cantonment Hospitals

At each of the cantonments for the new national army hospital provision will be made for 3 percent of the troops. At each cantonment a complete hospital containing at least 1,000 beds will be constructed, with a space reserved for extensions. Sixty acres have been allotted to each hospital and its auxiliary buildings. The hospitals will cost approximately $500,000 each.

One type is being used in all the hospital construction work done by the army. All the buildings are 24 feet wide, the length varying to meet the needs. The wards are usually 157 feet long, which is the size needed for 32 beds. There will be a diet kitchen for each ward, and a corridor connecting with the buildings on either side, which will be covered.

About 70 buildings will be comprised in each cantonment hospital on the 1,000-bed basis. In some cases two wards are joined, thus reducing the actual number of separate buildings, but the number of buildings will reach about 70, counting each ward as a building.

Each hospital will have a well-equipped laboratory, where bacteriological and pathological work can be done which any well-equipped hospital could handle. Some special tests will be made at the department hospitals, which will take care of any work that the divisional hospitals at the camps cannot attend to.

* * * *

Camps to Be Made Hospitals

The hospital train built at Pullman last summer for service on the border has been brought to the Pullman shops, where extensive alterations and repairs are to be made. Major W. L. Hart is now in Chicago directing the planning of a new hospital train of 280 beds, which is to be built and prepared for service at once. Madison Barracks, N. Y., has been designated as a hospital camp to accommodate about 2,000 patients, and it is expected that Fort Sheridan, Ill., Fort Riley, Kan., Leavenworth, Kan., and McPherson, Ga., will also be designated as hospital camps, with capacities varying from 2,000 to 5,000 men.

It is proposed to build a sufficient number of hospital trains to carry the wounded from the coast to these designated hospitals and take them back again to the coast when they are ready for the front.

DEPARTMENT OF NURSING

Conducted by MISS ANNIE W. GOODRICH,
Teachers' College, Columbia University, New York City.

Please address items of news and inquiries regarding Department of Nursing to the editor of this department, Teachers' College, Columbia University, New York City.

Public Health Nursing and the Public

BY ELIZABETH McCRACKEN, Washington, D. C., Editor of Home Progress Magazine, Author of The Women of America and The American Child.

We are accustomed to the thought that one of the most important elements in public health work is instruction; the visiting nurses not only nurse the sick persons whom they visit, but also teach the well members of the families and occasionally the sick members themselves the ways and means of keeping well and also just what good nursing is and how to do at least a portion of it. Certainly this is important. And it is very well done.

That is to say, it is well done among the poor—in the tenement districts. In such localities, among such people, one will often find a very intelligent and even fairly complete idea as to what public health is and what relation to it the visiting nurses have. Whenever this fortunate relationship exists in that particular public, it would almost seem as though there were little more needed in this direction.

But there is another, and that a very large, part of the community which lacks such instruction. This is the public living comfortably in suburbs and small cities, and in the more moderately priced houses and apartments of the large cities—people who, when they are very ill, can afford to have the entire time of a nurse. That is to say, they can afford this for a limited time. At the end of that time one comes upon their great need of knowledge of just what a visiting nurse is! They actually, in many cases, do not know. And their ignorance is dangerous, not only to themselves, but to others.

For instance, in the matter of caring for a young baby: the poor can usually have the services of a visiting or infant welfare nurse at least as long as she is urgently needed—sometimes they have her watchful care until the baby is one or two years old; the very rich have such care given by a nurse; but those mothers whose incomes are moderate do it themselves, after they return from the hospital, or from the moment they are able to be out of bed at home. In the case of a delicate baby, surely this is somewhat hazardous. And why do not babies of moderate means have a trained nurse for this period? The reason is that their mothers do not know, and, worse still, very often the friends of their mothers do not know, anything about visiting nurses, except that they wear a certain kind of dress and visit the sick poor. Only the other day a neighbor of mine was saying to me with real concern that she awaited with much apprehension the return home from the hospital of her sister, whose first child was about two weeks old. "The baby is so very frail, and my sister knows nothing about children; I am so afraid that she will not bathe the child properly, or in some other way do something not just right."

I at once suggested that she speak to her sister about the district nursing association in the place and arrange to have a nurse come every day and care for the child. She looked at once surprised and displeased. "A visiting nurse?" she exclaimed. "We are not yet in a class that has to have that sort of thing."

This is only too true. That is the pity of it. Unless that baby's aunt and that baby's mother, and very likely other members of the baby's family can be instructed in this matter of district nursing, and that convincingly, and moreover within a short time, the delicate little baby will be out of the class (made up of the very rich and the very poor) that does have skilled nursing, and in the class that is cared for by young, often nervous, usually frightened, and always untaught mothers.

One always thinks first of the relation to babies and young children of any educational or other activity which one would like to see extended. And it is, indeed, the case that the babies of those persons who do not understand what public health nursing is are the sufferers from this ignorance in whom one is most interested. But there are others. One important group consists of convalescents from serious illnesses. After an operation, for instance, or some such illness as pneumonia, the convalescent patient needs skilled nursing, a certain amount of it, for a considerable time after the regular nurses have left the case. Here, again, the very rich and the very poor usually have it; persons of moderate incomes often do not.

I know from my own experience that it is difficult to have, even though one may be so fortunate as to know something about district nursing. I happened, a few years ago, to have pneumonia. When convalescence began my physician said that I no longer needed nursing for more than one hour a day, and suggested having a visiting nurse. I followed this advice, but not without some difficulties. Not only several of my friends, but one or two neighbors protested to my family, saying that I ought not thus to hazard my recovery. One zealous acquaintance stopped my physician on the street to give him her views on the subject. "Pneumonia is such a serious thing," she informed him gravely, as he told me, "surely so long as any nurse at all is needed, she ought to be a trained nurse, of the regulation kind." My physician, who is a great supporter of visiting nursing, took time to explain to her that the nurses of that particular visiting nurse association had had not only the "regulation" training, but also additional courses in public health nursing, to fit them for their work. It happened, fortunately, that the nurse who chanced to come to me had graduated from the same hospital as the regular nurse I had been having, and had taken care of more pneumonia patients than she!

It is agreed among doctors, nurses, and other thoughtful members of the community that the "neglected age" is the reason for much ill health in mature life. It is during this age that children have many of the "children's diseases" and that adenoid growths occur. The only person who supervises their health during this period is, too often, the inexperienced mother. Of course, when a child becomes really ill, a physician is called in; but the nursing of that sick child, except in a few cases, is left to the mother, the illness not being serious enough to warrant a regular nurse. Can there be any doubt that many of the illnesses following measles, grip, and even bad colds, are due to the fact that the child had no professional nurse? This is a field for the public health nurse—a field almost entirely

uncultivated. When a child falls ill, it is a little too late to begin instructing the mother as to what the public health nurse might do for her. By the time she is fully convinced the child's illness is over.

Surgical dressing of minor injuries constitutes another important part of nursing which, in the homes of persons of moderate incomes, is usually done by a member of the family, and often not done well. Burns, for instance: how often they are badly treated! The result is, as in other amateurishly done surgical dressings, surface infection and danger of more serious poisoning. These patients do not have the advantage of the visiting nurses for such services, simply because they and their families have had no instruction as to what these nurses are and what they are for.

How does it happen that this important matter of instructing the public as to what instructive visiting nursing it, should be so neglected? Miss Gardner, in her book, "Public Health Nursing," says that nurses are seldom in the way of gaining practice in literary work, and that, even were they more often writers, they are too busy doing their work to write about it. It is true that amazingly few nurses are authors. But what occurs in regard to the placing of their articles when they are, seems to me almost as great a reason why what they have to say in nursing in general, and visiting nursing in particular, does not enlighten the particular public under discussion. Almost invariably they publish in professional magazines; hence their articles concerning their profession are read by the members of their profession and not by the general public.

Then, if I may be allowed to say so, it seems to my lay mind that nurses mingle too little, in their free hours, with a number of kinds of persons. One can readily understand that, since the nature of their work is such that they must do this very thing during their working hours, perhaps they especially feel the desire for their own professional group when off duty. But it certainly curtails their opportunities for making that for which they stand clear to the community. It is as though a clergyman should see only his own parishioners, and other clergymen, should never seek the rest of the world or encourage it to seek him, and should have no purely social, friendly intercourse outside his profession. It is quite certain that such a clergyman, whatever other power he might wield, would never be able to effect a full sense on the part of the public of what a minister is and what he is for!

What shall we do about it—this important matter of making known to that portion of the public which needs the ministrations of public health nurses and is not getting them, what a great force for the well-being of their families is at hand? Not only should nurses write more for publication, I think, but they should place their articles not merely in their own journals, but also in the general magazines. This will interpret them to many thousands of persons. Then, if it be at all possible, they should advance this instruction of the people by a more general social life. For, after all, one learns best about any profession from a friend who is a member of that profession. If among every nurse's friends there should henceforth be a few more who are not nurses, there would be considerable increase in the bulk of knowledge of what public health nursing is—and, more important still, exactly what kind of person, professionally, the public health nurse is.

However, we must not either ask or expect that the nurse will do everything in this matter. There is a great deal more that doctors may do than they are now doing in this field of instruction. In the first place, they, really better than anyone else, can gain the confidence of their own patients for the district nurse. There is, perhaps, no person whose opinion is so highly regarded by the public under discussion as that of the family physician. One must not, of course, forget that he has scant leisure for educational work among his patients, other than applies to the instructions he leaves with his prescriptions! But in the interest of those very instructions, he can do nothing better than take sufficient time to point the way to the best aid possible in having those instructions rightly carried out. It will take him less time than it will anyone else to make the person in charge in the family understand that neither he nor the apothecary can succeed without the nurse—and her work. Yes, doctors might do a very great deal more than they are now doing.

Also, there is a very great deal that any and every lay person who has some knowledge of public health work can do. For instance, members of clubs can use their influence to have lectures on the subject given before their organizations. Also, they can do their bit toward helping the local visiting nurse association with contributions, not only of money, but of what may be called local publicity.

There is not only the reason already suggested why the public of moderate incomes should be instructed as to public health nursing; there is still another reason. This is the matter of support. Public health is still very largely supported by private contributions. While many of these come from persons of large means, some of them come from those whose incomes are smaller—from that very group in which there are so many who do not understand the significance of the work, nor its elements. Did more of them know, more of them would help; when they do know, they will help. The greater the financial support, the greater the extent of public health work. And this support depends upon instruction.

We cannot afford not to give this teaching—in any way, in every way in which it can be given. That great part of the public of moderate means not now having the services of district nurses needs those services; these people need public health work. And the public health work needs them; their contributions are needed, and their cooperative sympathy is even more wanted. In the tenements, the district nurse instructs while she visits. In the suburbs and small cities and the comfortable, but inexpensive quarters of the large cities, she must instruct before she visits, or someone else must do it for her. Let her do it, or see that it is done, in order that public health nursing, not to say public health, may become more prevalent, to the greater well-being of us all.

The Movement to Increase the Number of Trained Nurses

The complete report will not be available for some time of the result of the wide appeal that is being made by the Committee on Nursing of the General Medical Board of the Council of National Defense, to young women to meet the need of the country for nurses, and the appeal to hospitals to provide for admission of a largely increased number of students. There are evidences, however, of a prompt response to both these appeals that are too interesting and too illuminating to be withheld until the final report is ready.

Miss Riddle has already given an interesting account of the Newton Hospital's efforts to meet the need, and to this we can now add a report of the course recently established by the Presbyterian School of Nursing, New York City, presented by Miss Alice F. Bell, a member of the faculty:

"The fourteenth of June, a circular was issued by the School of Nursing of the Presbyterian Hospital, stating

that plans were under consideration to provide through an increase in the numerical strength of the school, to meet in part the anticipated shortage of nurses attendant upon the unusual demands of the war. Through the generosity of interested friends, additional quarters were secured for the accommodation of an extra group of students to be admitted early in July. The housing problem, which at once confronts any school of nursing considering enlarging its staff, was thus temporarily solved.

"New conditions of entrance for students were also established, in that candidates with higher educational preparation, namely, graduates of approved colleges for women, having completed satisfactory work in science, were to be admitted on an advanced basis, which would permit them to complete their training in two years and three months instead of the customary three years. An arrangement was also made between the Department of Nursing and Health, Teachers College, Columbia University, and the School of Nursing in the Presbyterian Hospital, for a combination of courses in nursing leading to the Bachelor of Science degree, and the diploma of the School of Nursing.

"Candidates for admission to this course should have completed four years of high school and two years' work of collegiate grade in an approved college, normal or technical school. The professional course of three years is to include the regular theoretical and practical work prescribed by the Presbyterian Hospital School of Nursing, and, in addition, certain selected courses amounting to one year of work, or 32 points of credit in the School of Practical Arts, Teachers College. This work in Teachers College will be taken mainly in the first and last years of the professional course, and will be carried on concurrently with the work of the training school, the student being in residence in the hospital during the whole or main part of this period. The general plan of work in the School of Nursing includes instruction and training in medical, surgical, and obstetrical nursing, in the care of children, and in the diet school, dispensaries, and social service department of the hospital. In the third year arrangements have been made for training in visiting nursing in the Henry Street Nurses' Settlement.

"This endeavor to open up more freely to college women this field of public service has met with gratifying response. Several leading colleges, through their official publications, have brought the problem to the attention of the alumnæ, and urged the adoption of this opportunity for real service in the present national crisis and preparation for practically unlimited usefulness in the work of reconstruction inevitably following the war. Inquiries have also been received from members of college faculties as to the possibility of incorporating in the curriculum courses of study definitely related to the nursing field.

"In some 750 applications for admission to the School of Nursing received since the middle of June, inquiries have been received from nearly 200 college women, including some 70 with partial college training. All parts of the country and over 40 colleges have been represented. As to the personnel of the 22 students admitted in July, 50 percent were college women, representing seven different institutions, the remainder of the group having academic preparation equivalent to high school. The candidates listed for the October class show about the same proportion. In a group of 35 students are found 12 college graduates, 9 with two or more years, and 7 with one year of college work. This may serve as encouragement for advancement of admission standards in a state requiring only one year of high school as preliminary education for admission in Schools of Nursing."

Perhaps the most marked innovation and even more daring breaking down of tradition than the giving of credit in terms of period of service for college work has been made by the Bellevue Hospital Training School in its arrangement for an extern service or non-resident course. This course must of necessity be arranged on the basis of a forty-eight-hour week schedule. The pupils will receive no allowance and will meet their own maintenance expenses. In order that they may not lose the valuable experience offered by night service, some arrangement will be made whereby they can come into residence for a short period, possibly during the vacation months.

As the announcement of the course has only recently been issued, the first class not entering until December, it is not possible as yet to present any results, but the number of inquiries already received concerning the course leave little doubt as to its success.

The cooperation of the various schools of nursing with the visiting nurse organizations in this effort rapidly to train and mature a largely increased body of nurses, is also worthy of note. In New York City, through Miss Cadmus, superintendent of the Manhattan Maternity Hospital, several of the affiliating schools are arranging to send their pupils for a fourth or additional month of district maternity nursing under the supervision of the Henry Street Settlement nursing service. This experience will include prenatal, delivery, and postmortem nursing care. The Henry Street Settlement will meet the maintenance expense of these students, and the work will be arranged on a forty-eight-hour week schedule. These same conditions will obtain for the students from the Presbyterian School of Nursing that are to take the course of four months in public health nursing. Several other schools also have such an affiliation with Henry Street Settlement under consideration.

The Department of Nursing and Health, Teachers College, is arranging to open to undergraduate students a number of courses in public health nursing, and students who are obtaining their practical experience at the Henry Street Settlement will be given the privilege of attending two of these courses, the settlement meeting their tuition fees in addition to providing maintenance. We understand that similar opportunities are being given by the Visiting Nurse Associations of other cities.

Institutional Care of Infants

Jules M. Brady, S. B., M. D. (Arch. Pediat., 1917, XXXIV, No. 5), protests against the wholesale condemnation of infant asylums, and especially against the comparison with the boarding-out system made by Dr. Chapin. He presents an account of an experience extending over twelve years at St. Ann's Infant Asylum, St. Louis, conducted by the Sisters of Charity. Most of the infants are born in the institution, which has conducted with it a large maternity hospital. All the infants are fed artificially, but there are always present in the institution more babies than could be ideally cared for because of the desire of the sisters to extend the scope of the charity as much as possible. There are three wards for infants, each in charge of a sister trained in the care of babies. There is also a milk laboratory. The babies are cared for by a corps of nursery maids under training, who remain eight months. One ward contains from 60 to 90 babies and the other two care on an average for from 30 to 40. In 1912 Dr. Brady reported 170 babies cared for in the large ward, with a mortality of 10.5 percent. Largely through improvement in methods of artificial feeding, the mortality has been greatly diminished. He reports a mortality of 7.5 percent for infants older than 10 days admitted from September, 1914, when he became physician-in-chief at St. Ann's, to September, 1916. He mentions that St. Louis has the lowest infant mortality of any large city in the country. Ten years ago the death rate per thousand was 134.5; this year it is 182.1.

Brady concludes that the appalling mortality of infant asylums is entirely unnecessary. For successful care in an asylum, however, old-time methods of feeding infants must be discarded.

DEPARTMENT OF DIETETICS

Conducted by MISS LULU GRAVES,
Dietitian of Lakeside Hospital, Cleveland, Ohio.
Please address items of news and inquiries regarding Department of Dietetics to the editor of this department, Lakeside Hospital, Cleveland, O.

In this department will be found an announcement of the conference of dietitians to be held in Cleveland October 18-20. Not only is it to the interest of every dietitian to be present at this meeting, but it is her duty.

Frequently in the past this department has urged the dietitians to get in close touch with each other. We know very little of the work being done in hospitals other than the ones with which we are immediately associated. In an effort to learn more of the conditions in various institutions we found that in the majority of hospitals very little dietetic work is being done, though a few hospitals are laying the foundation for the building of splendid departments.

At the American Hospital Association there was some discussion of the dietary department and, incidentally, the dietitian. The general trend of opinion was toward the centralization of the commissary department, with one woman in charge of the entire work. This means a woman with executive ability as well as a knowledge of foods. If she is to work with the physician in diet for disease, she must have a scientific background as well. The dietary department is going to be put on a very much different basis and the status of the dietitian greatly improved. It behooves those of us who are now in the work to get in the front ranks.

We are anxious to have a complete mailing list of dietitians. You will be sure of being on this list if you send your name and address to the editor of this department. Should you wish a program of the meeting, please send your address at once.

* * * *

Conference of Dietitians

A conference of dietitians is to be held at the Hollenden Hotel, Cleveland, Ohio, October 18-20, and superintendents of hospitals and similar institutions are specially requested to have their dietitians attend.

That there should be an opportunity for the dietitians of the country, particularly the hospital dietitians, to come together in conference and to meet with the scientific research workers has long been felt. Now that our national crisis requires conservation on every hand, it seems highly important that the several hundred dietitians of the country who have the feeding of many thousands should come together to discuss conservation and the food problems of the day.

A very interesting and profitable program has been prepared, including sessions on foods and nutrition, diet in disease, and institution management, as well as conservation. A number of prominent speakers have been secured, including Mrs. Caroline Bartlett Crane, chairman of the Women's Committee of the Council of National Defense for Michigan; Dr. Ruth Wheeler, University of Illinois; Miss Mabel Little, Cornell University; and Dr. Harold O. Nolan, Interstate Medical Journal. The program will include a number of round-tables and discussions on important topics, and also visits to the various hospitals of Cleveland.

Altogether the meeting promises to be a most important one, not only for the dietitians, but for the hospitals and institutions with which they are affiliated.

The meetings will be held in the Hollenden Hotel. Those wishing accommodations at the Hollenden will please write Miss Lulu Graves, Lakeside Hospital, Cleveland. The rates are: single rooms, $2 and up; double rooms, $3.50 and up. Accommodations may be had at other convenient hotels, rates being as follows: Statler Hotel—single room, with shower, $1.50 and up; double room, with shower, $3 and up. Euclid Hotel—single room, $1.50 and up; double room, $2.50 and up. Olmsted Hotel—single room, $2 and up; double room, $3 and up. Colonial Hotel—single room, $1.50 to $3; double room, $2.50 to $4.50. Y. W. C. A.—rooms, 50 cents, 75 cents, $1; breakfast, a la carte, 15 cents; luncheon, a la carte, 15 cents; dinner, table d'hote, 35 cents.

Those wishing printed programs will please write Miss Graves, Lakeside Hospital, Cleveland, or Miss Lenna F. Cooper, Sanitarium, Battle Creek, Mich.

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Conservation of Food

BY DR. J. A. WESENER and GEORGE L. TELLER, of The Columbus Laboratories, Chicago.

[Continued from the September issue.]

We, therefore, hold to the view that white bread, from a purely nutritive standpoint, is far better for the consumer, both economically and nutritionally. In discussing a subject of this kind, the physical ailment, such as constipation, must be entirely discarded, as that is a factor which should be treated along medical lines and not carried in as one involving a question of feeding. The more nearly we can secure 100 percent digestibility in the use of our foods, the better shall we succeed in the economical phase. If we take a food in which the nutritive elements are capable of 100 percent digestibility, and introduce disturbing factors, such as fiber, which bring on excessive peristaltic action, a considerable portion of these nutritive elements will be discharged from the bowel, for the reason that they are not given the opportunity of lingering there long enough to be completely digested and assimilated.

We have always looked upon whole wheat and graham breads more as medicinal foods than as ordinary foods. They are always spoken of as health breads, and the great slogan has been that they contain all of the elements of the wheat berry, plus enough of the roughage to bring about good, healthy peristaltic action. And, in this connection, it must be remembered that while whole wheat and graham flour represent practically the whole wheat berry, therefore you would think it would sell for less money than the refined flour, but just the contrary is true in that a fancy price is demanded for these products. A patent flour represents about 65 percent of the whole wheat berry and naturally, therefore, should sell for more money than the whole wheat or graham flour. In the present crisis of food shortage, it should be the duty of all manufacturers of foods to strive to get 100 percent of yield. The offals, such as bran from the wheat berry, and bran material from other cereals, should not be incorporated in the finished product, even if the output and volume thereby are increased. It is far more economical and advisable to use the refined 100 percent digestible food product as food, and

then, if the medicinal factor is involved, it would be cheaper to feed such individuals on agar-agar or wood sawdust. Either one of these would give them sufficient roughage and at a minimum cost.

While we have shown very clearly that the fiber in whole wheat and graham flour is not the factor demanding the high premium on such products, there are other elements present in the whole wheat and graham flour which are very necessary from a purely nutritional standpoint, and these also have important bearings on the well-being of the individual. These we shall discuss in our next article.

[To be continued.]

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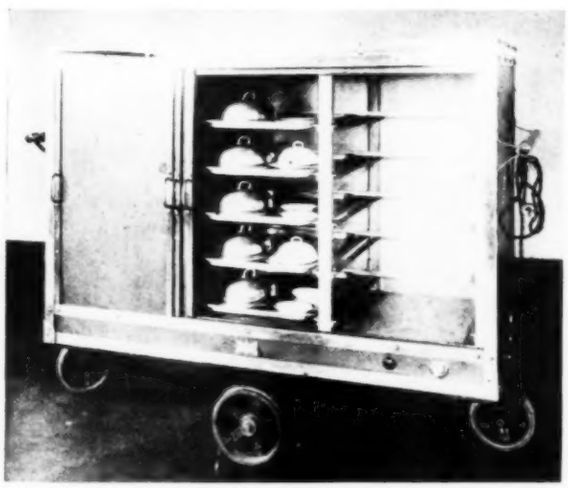
AN ELECTRICALLY HEATED FOOD TRUCK

How the Massachusetts General Hospital Solves the Problem of Hot Meals for Patients in Rooms Distant from the Kitchen

BY JOSEPH B. HOWLAND, M. D., Acting Administrator of the Massachusetts General Hospital, Boston.

The difficulties of providing in a satisfactory way hot meals to patients located some distance from the kitchen are only too well known to hospital superintendents.

The Massachusetts General Hospital made a careful study of the different methods in use in the private wards throughout the country, and in no case were we quite satisfied that the problem had been wholly solved. We therefore decided to experiment with an electrically heated truck, which, after several months' service, has proved so satisfactory that I think it may be of interest to the readers of THE MODERN HOSPITAL. The accompanying illustration shows most of the interesting points of the truck.



Electrically heated food truck in use in the Massachusetts General Hospital.

The truck is lined with galvanized iron. The exterior is of black Russia iron. All walls, top and bottom are insulated. In the floor are located three electric stoves, each of which may give either a high or a low heat.

In our private ward we have a truck for each of the eight floors, made to hold as many trays as there are bed patients' rooms on each floor. Our method of using the truck is as follows:

Before each meal the trucks, which are kept in a room for that purpose, are connected with wall plugs and are thoroughly heated. They are then wheeled to the kitchen, one at a time, where they are again connected with an electric plug to insure a continuance of the heat. Trays for each floor—after the meal is served—are then slid into grooves having spring clips, which hold the trays tightly in place. The doors are closed and the truck is then sent to the diet kitchens on the different floors. On arrival, they are again connected to the electric current. If the inside is found to be too hot, the heat may be turned down or turned off. Each tray is removed as it is required and the dishes set up again on a cold tray, which has been arranged with cloth, silver, etc. Cold dishes are sent to the diet kitchen on the top of the truck, which is provided with a rail to prevent the receptacles from slipping off.

Although our private ward is an eight-story building, meals served on the top floor are as hot and attractive when the patient receives them as though taken directly from a range close at hand.

* * * *

HEATED FOOD BOXES FOR SERVING HOT FOOD FROM A CENTRAL KITCHEN

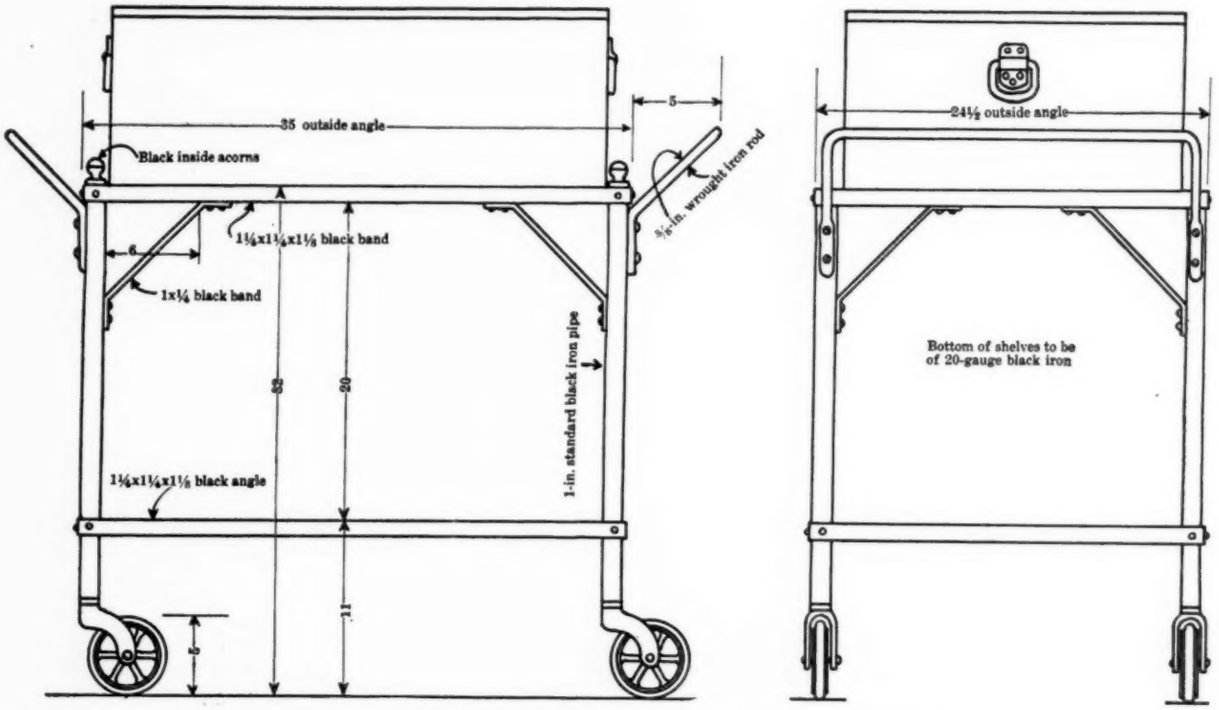
Food Served Hot at the Bedside in Wards of Philadelphia General Hospital by Utilizing the Principle of the Fireless Cooker for Food Boxes

BY HELEN L. WALLACE, Chief Resident Dietitian Philadelphia General Hospital.

Food distribution in a large institution is a problem to be worked out by all dietitians. The floor plan and centralizing of food preparation will regulate various features which are met differently according to these points.

The method which I am requested to explain is used in a municipal hospital where the average number of patients fed per meal is twenty-five hundred. The food is prepared in one general kitchen—at this point placed in food boxes especially designed for our use. These food boxes are constructed on the principle of the fireless cooker; that is, are insulated with half-inch asbestos lining, and are of sufficient size to hold five food containers of the usual steam-table equipment style, from which fifty patients may be served.

Fig. 1. Heated food box and iron truck for the distribution of hot food from a central kitchen throughout the wards in Philadelphia General Hospital.



Figs. 2, 3. Construction diagrams of Philadelphia General Hospital warm food trucks. The truck is enameled white, and has four rubber-tired swivel casters. For details of food box see Fig. 4.

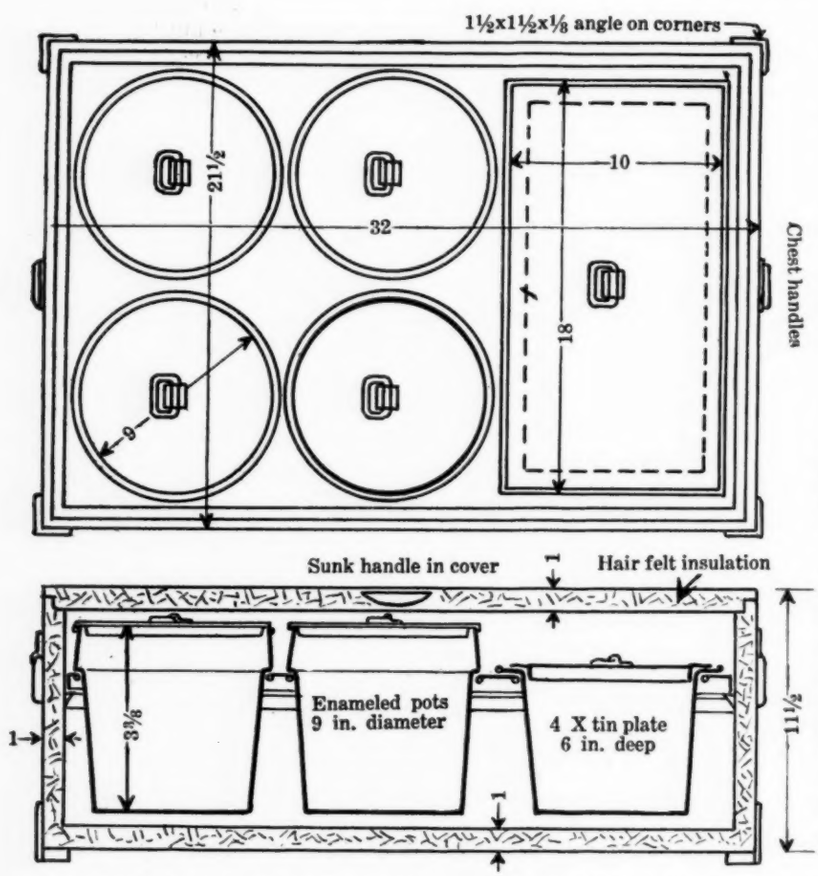


Fig. 4. Details of construction of Philadelphia General Hospital hot food boxes. All containers are to have flat tin covers with small drop handles. The outside of the box is to be of No. 20-gauge galvanized iron; the inside is to be lined with 4 X tin.

If these containers are heated when the hot food is placed in them, because of the heat-retaining properties of the interlining the food will be the proper temperature at serving time.

From actual experiments, the temperature, which had originally registered 212 F., dropped during a period of five hours to 160 F.

Eight of these boxes are placed on an electric truck and quickly taken to the central kitchen of each department.

The number of wards in the different departments varies from three to ten, but each ward has its own food box plainly marked.

For each box a light angle-iron carriage has been constructed on the idea of a tea wagon, with two shelves. Upon these shelves may be placed a pitcher of milk, bread, soft diet, desserts, etc. Each box is placed upon its carriage and wheeled directly into a ward.

About five minutes previous to the hour of serving the diets, trays are placed upon each patient's bedside table, containing the necessary cold dishes for the serving of the diet. The serving plate is kept in the department kitchen steam cabinet and placed in the lower shelf of the carriage when the food box is delivered, so insuring the warm plates. As the carriage is wheeled through the ward, hot food is served at each bedside by a nurse in charge.

All special diets are prepared in a separate diet kitchen, in which the student nurse receives her practical training in dietetic therapy. These diets are marked and sent to the kitchen of each department and served by a nurse to the ward in which the patient is.

DISPENSARY AND OUT-PATIENT WORK

Conducted by MICHAEL M. DAVIS, Jr.,
Director of the Boston Dispensary.

Please address items of news and inquiries regarding Dispensary and Out-Patient Work to the editor of this department, 25 Bennett street, Boston, Mass.

The Boston Dispensary in Its One Hundred and Twentieth Year*

In September, 1796, seventy-four citizens of Boston subscribed their names to an agreement establishing the Boston Dispensary for the sick poor of their city. The institution which they then founded is thus the oldest medical organization in Massachusetts and the third oldest in the United States. The names of those who signed the parchment, which hangs today in the dispensary's office, include some of the leading men of the Commonwealth at that time, Samuel Adams among them.

At its beginning the Boston Dispensary had merely an office in a drug store, located in what is today the heart of the business section of Boston. Here medicines were dispensed on the prescription of the physician of the dispensary. He visited the patients in their homes, and during the first year Dr. John Fleet, the one doctor, treated 80 cases. Boston was then a town of 20,000 inhabitants, and this was, therefore, one patient for every 250 of the population. In 1916 the Boston Dispensary had about 40,000 men, women, and children as patients, and as approximately 32,000 of these came from within the city limits, about one in every 23 men, women, and children in Boston received care from this institution.

Fig. 1. The Boston Dispensary.

An effort to prevent that "dispensary abuse," which still tries the souls of certain practitioners and superintendents, is apparent in the early days of the Boston Dispensary. Every person who subscribed $5 or more to its funds was supplied with a card which he could give to "deserving poor" of his acquaintance, and these "worthy objects of charity" could secure the services of the physicians on presentation of these cards at the dispensary. For each $5 given by a subscriber, two patients might be "kept going" by him at one time.

But, as the City of Boston grew in size and the number of physicians and beneficiaries increased, the requirement of a personal introduction for each patient became cumbersome. Besides, the physicians, instead of merely seeing patients in their homes, began to see patients at the dispensary itself, or sometimes in their private offices. Dr. Oliver Wendell Holmes, who was a district physician of the Boston Dispensary in 1837, found the ancient system of cards from subscribers so inconvenient that he wrote a letter to the board of managers, as pungent as we should expect from the Autocrat of the Breakfast Table, and in this letter he urged that the old plan be abolished and that a clinic should be provided, "to which such patients as can safely and conveniently leave their own residences shall be expected to resort for advice."

Dr. Holmes' suggestions were shortly followed. Cards from subscribers were abandoned. Organized out-patient clinics were established. The dispensary moved in 1856 to its present site, only about half a mile from its original location. The small building which it then occupied was torn down in 1883 and replaced on the same land by a much larger structure. This in turn has been four times increased since then. The original work of the Boston Dispensary was, as we have seen, the treatment of the sick in their own homes, and this has continued until the present time. The municipality of Boston has remained one of the few in the United States which does not provide treatment for the sick poor in their homes. The early establishment of the Boston Dispensary and the service rendered by its district physicians for four generations, is doubtless the reason for this unique situation.

But the out-patient clinics caring for ambulatory cases increased by leaps and bounds, whereas the treatment of patients in their homes grew but slowly. In recent years, owing to the greater use of hospitals and other conditions, the district work has not increased at all. The main service of the dispensary is today in out-patient clinics. These are the central features, in spite of the fact that since 1912 a hospital for children with twenty-six beds has been maintained.

But with 15,000 babies and children under care annually, a small hospital ward becomes, as may be imagined, rather an adjunct of the children's service in the out-patient clinics and not the overshadowing feature of the children's work as a whole.

The accompanying table shows what the Boston Dispensary does today:

*Prepared at the request of THE MODERN HOSPITAL by Michael M. Davis, Jr., director of the Boston Dispensary.

WHAT THE BOSTON DISPENSARY DOES

MORNING CLINICS

Open daily. Small fees charged for admission, medicines, operations, etc.; remitted when necessary.

	New patients (1916)	Visits
General medical (adults)*	3,581	16,005
Children's medical*	2,772	14,162
Surgical*	2,768	11,179
Genito-urinary*	1,019	14,278
Gynecological*	980	6,796
Nose, throat, and ear*	3,328	11,549
Eye	2,405	9,085
Dental*	1,978	4,032
Dermatological	1,887	8,409
Orthopedic	743	3,146
Rectal, x-ray, neurological, children's preventive, gymnasium, massage	1,456	8,218
Total morning clinics	22,917	106,854

*Teaching clinics, Harvard or Tufts Medical School, or both.

EVENING CLINICS

On a self-supporting basis, especially for wage-earners. Fees charged which cover cost. Medical staff salaried.

	New patients (1916)	Visits
Eye	548	1,294
Genito-urinary	551	8,195
Syphilis	188	1,671
Nose, throat, and ear	91	358
Total evening clinics	1,378	11,518

A general medical evening service will be opened during 1917.

PATIENTS TREATED IN THEIR HOMES THROUGHOUT BOSTON BY OUR DISTRICT PHYSICIANS

Patients during 1916, 7,079. Visits paid by the doctors to their homes, 11,941. Nursing service provided by the Instructive District Nursing Association of Boston.

PRESCRIPTIONS

Prescriptions of medicine issued, 1916, 60,527. Eyeglasses, orthopedic plates, or surgical appliances furnished to over 3,000 patients. Prices near cost. Payment by installments arranged.

THE X-RAY DEPARTMENT

Does work for dispensary patients; also for patients of private physicians who can pay a doctor, but not the regular private fee for an x-ray. The laboratory provides full clinical service.

THE HOSPITAL FOR CHILDREN

Beds for babies and children up to 12 years, 26. Patients, 1916, 453. Hospital days, 7,483. Every child followed up for at least one year after discharge. Harvard and Tufts teaching in the wards. Three months' course in pediatrics for pupil nurses from affiliated hospitals.

SOCIAL SERVICE

Special workers assigned to the larger clinics. Social histories taken of all patients therein. Cases taken up for intensive social work, 1,915. Patients receiving minor social service, about 8,000. Students in medical social service trained.

THE STAFF

Physicians on official staff of clinics, 90. District physicians, 7. Employed staff (nurses, social workers, pharmacists, engineers, orderlies, servants, etc.), 90. Volunteer workers and social service students annually, 30 to 40.

What are the principles which have governed the organization of these out-patient clinics of the Boston Dispensary? They are:

1. *Cooperative diagnosis.*

The organization of a series of clinics in charge of specialists all in action at the same time, with the administration such that joint examinations of patients or consultations by different specialists are facilitated and the resources of x-ray, laboratory, etc., made readily available.

2. *The institution is responsible not only for diagnosis, but for treatment, and must endeavor to make it possible for the patient actually to carry out the treatment.*

This implies individual attention to the patient so as to decide at every visit whether he needs to come back again for treatment or to be sent to a hospital; and a follow-up system, which will tell us whether or not the patient does what he should and will get after him if he does not.

3. *Clinics must be adapted to the needs of those people in the community who need their facilities.*

This means morning clinics with nominal fees, remitted whenever necessary. It also means evening clinics to meet the needs of wage-earners who can come during the daytime only at a serious sacrifice of wages. Since many self-supporting wage-earners, as well as the very poor, need the services of the clinics, the evening clinics should be based on the principle of self-support, charging fees corresponding to cost, and provide a salary for their medical staff.

4. *Social problems of patients are involved with their medical problems, and both must be diagnosed and dealt with to secure the best results with either.*

Social service is important to a dispensary or hospital chiefly because of its contribution to the medical results. To be most effective the Social Service Department must be an integral part of the institution, not under merely affiliated management. The social workers must go into the clinics and have first-hand contact with patients, as well as take such cases as come to them on the suggestion of others. They must survey the social problems of patients in groups. They must cooperate with other charitable agencies, in making the resources of the medical institution useful to non-medical organizations in the community.

5. *The dispensary must be a center whence new knowledge is disseminated.*

The dispensary must be a teaching institution. Its medical and lay workers must teach themselves to do their jobs better. They must teach medical students, nurses, and social workers, and also do their best to teach the community more about the curing and preventing of disease. They must seek new knowledge from the rich material which is at hand. Each of the thousands of dispensary cases presents its problem of illness; each its human and economic problems as well. From some cases medical science can learn; from others, light can be shed on broad questions of public health and on community needs. These educational possibilities must be made real, and the results of the medical and social studies must be interpreted to the community through publications.

6. *The government of the institution must be made cooperative to make it most efficient.*

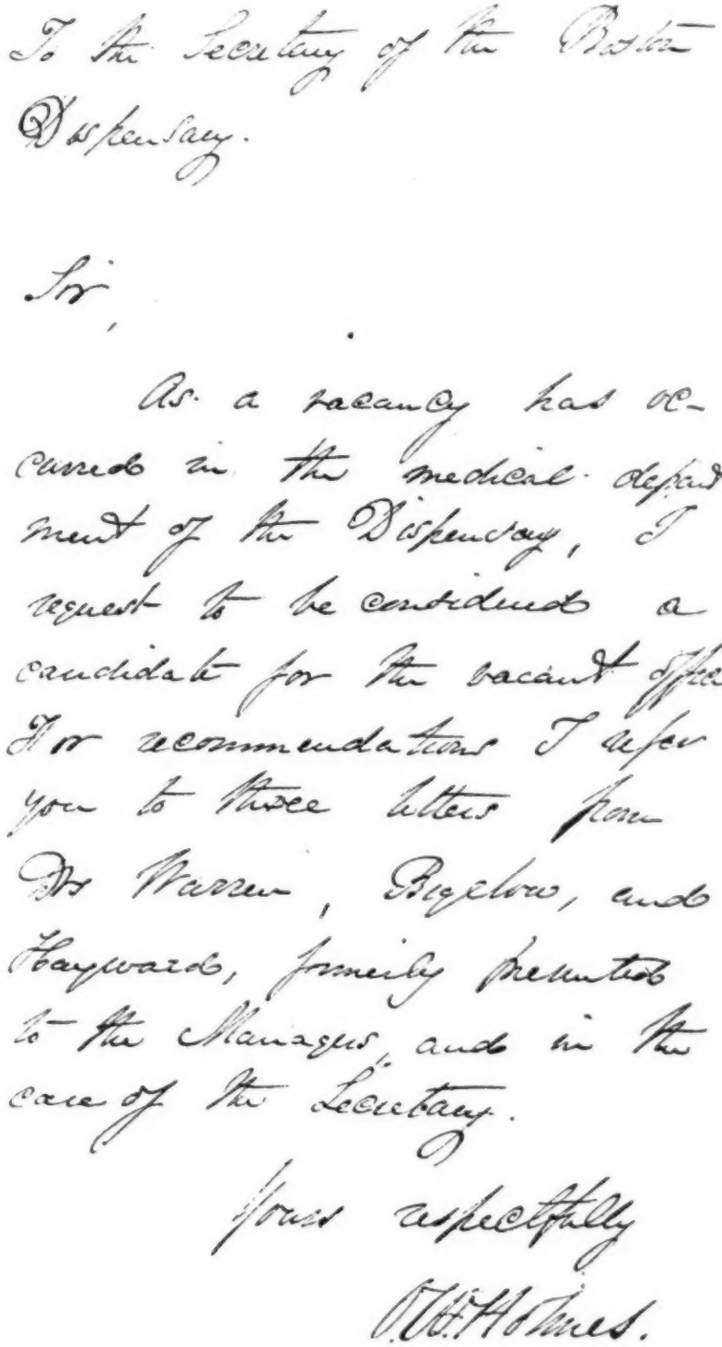
Everybody who works in it, medical and lay, needs not only to be doing his or her work, but to be thinking about it and be transmitting his or her thoughts and suggestions to the central management.

With this ideal in mind, the Boston Dispensary, subject to the general authority of its legally constituted board of managers, has a joint council in which five members of the board, four of the medical staff, and three of the executive officers meet monthly as the central advisory body of the institution on questions of policy and administration.

In the hospital for children in the Boston Dispensary the same principles have been applied to the special problems connected with ward cases. The follow-up system of the hospital does not mean merely fishing up the patient's record at the end of a year after the child's discharge; it means that at the moment of the child's discharge and for not less than a year thereafter, often for several years, the cases are continuously followed through the social service worker attached to the hospital. Regular reports of the child's condition are presented, and, whenever there is need, the child is kept under supervision in the children's out-patient clinic. The stay of a child in the hospital is not regarded as an event complete in itself, but as merely a stage in a continuous process of maintaining and promoting that child's health.

The district physicians of the Boston Dispensary constitute the third main department of this work. Seven men, each of whom receive a salary for part-time service, are appointed. Affiliations are established with the Harvard Medical School and with the Tufts Medical School, and provide for certain fellowships, which give the incumbent teaching opportunities in connection with the district service. The teaching of medical students at the bedside of patients in their homes is a valuable experience for a student, although it must be administered with care

in order to minimize obvious difficulties and objections. Two fellowships are also offered for men desirous of entering public health work, such that the incumbent of these fellowships may work for a degree or certificate in public health, giving half their time to study and half to the district work of the dispensary. This furnishes many opportunities for the practical observation and study of health conditions in the homes.



To the Secretary of the Boston Dispensary.

Sir,

As a vacancy has occurred in the medical department of the Dispensary, I request to be considered a candidate for the vacant office. For recommendations I refer you to three letters from Dr Warren, Bigelow, and Hayward, formerly presented to the Managers, and in the case of the Secretary.

Yours respectfully

O. W. Holmes.

Fig. 2. Facsimile of a letter from Oliver Wendell Holmes, applying for a position on the staff of the Boston Dispensary.

In 1886 the Instructive District Nursing Association of Boston was founded for the purpose of providing visiting nurses for the district physicians of the Boston Dispensary. Now, after more than thirty years of existence, the work of the association has greatly broadened, but nursing for the "district doctors" still constitutes a substantial part of their work.

The war is now facing the Boston Dispensary with new and serious problems. The medical staff will be greatly diminished, owing to enlistment. The higher cost of food, fuel, drugs, and almost all kinds of supplies has increased financial burden as with all hospitals. Higher prices make living conditions harder for wage-earners and for all of small means, and may be expected to bring a growing number of cases of malnutrition, especially among children, and of diseases connected with a poorer food supply. An increase of pressure upon workers in certain industries is already apparent because of war, and is likely to extend much further. A medical institution, during this period of our national life, bears an especial responsibility for conserving one of the nation's most valuable assets: the health of its wage-earners and of its children. Upon the wage-earners, the producers of food, munitions and supplies, we must depend today for success in war as much as upon the soldiers; upon the children the nation must rely tomorrow for its very existence, and any cause which threatens the vitality of its children is a blow at the country's future.

Under these conditions the Boston Dispensary feels an especial call to develop in every possible way its curative and preventive service to children and to expand its work for wage-earners, as by increasing its evening clinics. What other calls the future may hold cannot now be foreseen. An institution which has lived through every one of our country's wars since the Revolution must face the problems of this greatest, and, we trust, the last of all wars, with a courage worthy of its past.

Twelve of the 17 hospitals of Westchester County, New York, have organized the Westchester County Hospital Association, and it is expected that the five other institutions will become members. Mr. C. Arthur Speakman, president of the board of trustees of the Mt. Vernon Hospital, is president of the association; Dr. Robert Denniston, of the Dobbs Ferry Hospital, is vice-president; and Mr. John R. Shillady, executive secretary of the Committee on Cooperation with Red Cross War Relief and Health Agencies of the Westchester County Commission of General Safety, is secretary and treasurer. The new organization is taking up as its first problem the question of encouraging young women to enter training schools for nurses, and the advisability of some of the county's hospitals combining to employ an expert supervising nurse for teaching purposes, this expert to divide her time among several hospitals, none of which might be able alone to support her.

Miss Clara F. Sollenberger, superintendent of the Altoona Hospital, Altoona, Pa., is leaving that institution to take a similar position in the South Carolina Baptist Hospital at Columbia.

INDUSTRIAL WELFARE

A NEW INDUSTRIAL HOSPITAL PLAN

Northeastern Hospital of Philadelphia to Serve Corporations on a Cooperative Basis—Some of the Details

BY BARROW B. LYONS, Financial Executive, Philadelphia.

A cooperative health service is now being developed for the mills in Northeast Philadelphia. Hitherto large plants, such as the Bethlehem Steel Company, the Cadillac Motor Company, and the Norton Grinding Company, have organized company health departments; but a cooperative health department for a number of mills is a new departure in organized medicine. By this means the mill with two hundred employees may receive the same service as the mill with ten thousand employees, for a proportionately less cost.

This is a business proposition—not a charitable one. The mills benefit directly through the increased efficiency of their employees, and indirectly in dollars and cents. The employees benefit through better health and greater earning capacity. While this is a business proposition, the hospital will secure no profit from the organization, but will maintain it on a self-supporting basis.

There will be five classes of service offered at first. They are as follows:

Class A—Workingmen's Compensation Service:

1. Preferential care of employees of cooperating firms when a number of patients are visiting the hospital.
2. Hospital care for bed patients. Fee $1 per day; fees for special care according to a standard list of prices.
3. Instruction in use of first-aid cabinet.

Class B—Medical Inspection:

1. Thorough physical examination of all persons employed, including examination of blood pressure, and urine when patient is over 40 years of age.
2. Thorough examination of all applicants for work, including examination of blood pressure and urine.
3. Reexamination when patients are transferred from one department to another.
4. Cases needing attention to be referred to the patients' private physicians.
5. Monthly report of men examined in each plant.

Class C—Medical Inspection and Treatment:

1. Medical inspection as in Class B, and in addition general medical treatment, including special treatment for eyes, nose, throat, nerves, etc.
2. Monthly report of all cases treated and examined in each plant.

Class D—Medical Treatment to Referred Cases Only:

1. Under this class of treatment only patients would be treated who are referred to the hospital by business firms subscribing to the service.
2. Monthly report of all cases treated in each plant would be made.

Class E—Social Service:

1. A social service worker for each group of factories, employing a total of about 2,500 workers, monthly salary of $85 to be paid by mills to hospital on pro rata basis. Social service workers to be in the employ of the hospital.
2. Visits to be paid at home of every worker who does not ring in for work in the morning.
3. Usual social service work in connection with sickness and poverty.
4. Monthly report of work done for each plant.

It needs no argument to prove that an employer insured under the workingmen's compensation law of Pennsylvania ought to receive the full benefit of that insurance by securing the best possible treatment of injured employees.

A special study of handling industrial injuries will be made by the Northeastern Hospital, and it is hoped that suggestions of value for all who treat industrial injuries will be evolved.

The hospital, moreover, on request will give instructions in the use of the first-aid cabinet to persons responsible for their use in firms which send their injured employees to the hospital. An effort will be made to impress upon these cooperating concerns the efficiency of first-aid treatment, particularly in reducing infections from cuts and lacerations, and therefore in reducing the working days lost because of injuries. The necessity of always following first-aid treatment by inspection or treatment by skilled physicians will not, however, be overlooked.

Northeastern Hospital of Philadelphia, Allegheny avenue, erected by Ballinger & Perrot, architects and engineers.

But the need of medical inspection in plants will be emphasized fully as much as the need of treatment for injuries. W. Irving Clark, M. D., who has accomplished remarkable results in increasing the efficiency of employees of the Norton Company and the Norton Grinding Company, of Worcester, Mass., gives the following reasons why physical examination of workingmen is of advantage to the employer:

1. It enables the employer to select men for the work to which they are best physically fitted.
2. It enables the doctor making the examination to instruct and advise employees of any defects which they have and of which they are not aware, and by enlisting their cooperation enables them to overcome these defects where possible, and thus to increase their physical efficiency.
3. It prevents the introduction into the factory of men who are undesirable because of severe defects.
4. It prevents contagious diseases coming into the factory and becoming established there.

The physical advantages to the employees correspond, of course, to the advantages of the employer.

Moreover, Dr. Clark points out that the employee feels, after he has received a physical examination, that the factory is taking a personal interest in his condition and that he can go to the doctor for further advice if he considers it necessary. Dr. Clark believes that this is a very important factor in holding the loyalty of many employees, as the employee is pretty sure to feel that the factory is not employing a man who is not perfectly competent to handle any condition which he may have, whereas he usually cannot afford a family physician.

When a special examination is made each time a man is transferred from one department to another, a periodical

examination of the entire force is not necessary. This examination, when a man is transferred, shows whether or not the man is physically fitted for the new kind of work which he is taking up. Under the system employed by the Norton Company, all men applying to the hospital for treatment are thoroughly examined if there is anything indicating the necessity for such an examination.

Under existing industrial conditions, men are seldom refused work because of their physical condition, except for some very evident defect. Even though all applicants were thoroughly examined, it would not be necessary to reject more men than are rejected at present. The value of the examination would be in giving them work for which they were fitted.

An examination would bring to light many defects which disqualify men for work. Men having vision reduced to one-half in both eyes, others carrying contagious diseases, others having more than second-degree hernia, cases of heart trouble with disturbed compensation, cases of varicose ulcer, cases of fourth- and fifth-degree flatfoot, where the arches apparently give trouble, all would come to light in a physical examination. Even in these times of great labor shortage, working men with such defects are a liability rather than an asset.

The third class of service which the hospital will offer carries to its logical conclusion the second class. Instead of being referred to private physicians as under the second class employees would be treated at the hospital. With the laboratory facilities, special appliances, and the staff of specialists of the hospital, the employee would, as a rule, receive better treatment and would be returned to work more rapidly than if he went to a general practitioner.

In this case the hospital suggests that the funds for meeting the cost of this service be raised through the organization of a mutual benefit society, similar to that of the Cadillac Motor Car Company and the Westinghouse Electric Manufacturing Company. Membership of the employees in this is compulsory and is maintained by small dues collected from their pay envelopes.

In response to letters which the Northeastern Hospital of Philadelphia sent to a number of firms, questioning them as to the value of medical and surgical care of employees, not one answer was received which indicated that the service did not pay for itself. The first question asked was: "Do you find the surgical and medical care of unskilled laborers pays for the service?"

The Cadillac Motor Company, of Detroit, replied to this question: "We are satisfied beyond any doubt that the medical and surgical care of skilled and unskilled laborers more than pays for the service. The medical care is more than justified by the increased efficiency of the men, and the surgical case has proven to be a big economical factor from the standpoint of workingmen's compensation law, and, of course, of greater value from the standpoint of greater efficiency of the working men."

The Brown & Sharpe Manufacturing Company, of Providence, R. I., said: "We do not draw any distinction between skilled and unskilled help, as to the value of medical and surgical care, believing that it is of equal importance for both classes, even more so in the class of unskilled laborers, because of their need of advice and guidance in lines of health safety."

Sears, Roebuck & Company, of Chicago, said: "We have found the medical and surgical care of our unskilled employees a very beneficial affair. We have also found it a paying proposition."

The Solvay Process Company, of Syracuse, N. Y., said: "Medical and social service does not pay in dollars and cents directly; the result is indirectly from the increased efficiency of labor. We believe in that respect it not only pays, but is absolutely necessary, and we are extending this line of work as rapidly as possible."

The fourth class of service offered is merely for the medical treatment of cases which are referred to the hospital by the mills. It would be considerably less expensive than examining all employees and treating them when defects were found, but, on the other hand, it would have no effect in preventing sickness and disease in the factory.

Social service comprises the fifth class which the hospital offers. A social service worker visiting the home of an absent employee on the first day on which he does not report for work would immediately convince the employee and his family of the solicitude of the firm for his welfare, provided, of course, the social service worker were tactful and sympathetic. Moreover, it would tend to prevent employees from staying home because of slight illnesses or simply because they did not feel like working. It would also make prompt medical assistance possible, and check in the beginning many diseases which, if not promptly treated, would become more serious.

In regard to social service work, the Solvay Process Company said: "We of course have a social service department, and believe it to be as necessary as any other department."

The Brown & Sharpe Manufacturing Company replied: "We have an industrial department which cares for social service work, and believe that it is of growing importance to give consideration to matters which naturally come under this heading."

The Cadillac Motor Car Company said: "About the only work we do along this line is done by our visiting nurse, who is a graduate of one of the local hospital training schools, and who is giving her special attention to the home conditions and physical illness of the young women employees. This work has not been extended to our shop employees."

In planning for the new Northeastern Hospital of Philadelphia, the idea was to organize an institution which would render 100 percent efficient returns for the money invested. For this reason an industrial dispensary rather than a large general hospital was determined upon. Those who know the mill districts of Kensington and Port Richmond in Philadelphia fully realize the great public necessity for an institution which will prevent disease and teach healthier living rather than simply cure disease.

In order to treat our dispensary patients needing hospital care, and to care for people injured in the mills, a small but well-equipped general hospital will be maintained in connection with the dispensary. The institution will not only care for such cases as are brought to it for treatment, but will also actively seek out the causes of disease in the homes and the mills. To do this, we intend to organize a department for the prevention of disease. As a result of its investigations, it will make recommendations to the health department, the schools, and the mill owners, and endeavor to have its suggestions put into effect.

The plans for the department for the prevention of disease have not yet been thoroughly worked out. The intention is to secure the services of an epidemiologist to head the department. Not only preventive work in the homes of the neighborhood, but in the mills, will be undertaken. Occupational diseases will be studied in connection with the health inspection in the mills.

Although the plant of the new hospital will not be large, its use will be intensive.

BOOK REVIEWS

Social Diagnosis. By Mary E. Richmond, Director Charity Organization Department Russell Sage Foundation, Author of "The Good Neighbor," etc. Pp. 511. Cloth, price $2.50. Russell Sage Foundation, New York, 1917.

This book is the result of studies which Miss Richmond began fifteen years ago. She says:

"With other practitioners—with physicians and lawyers, for example—there was always a basis of knowledge held in common. If a neurologist had occasion to confer with a surgeon, each could assume in the other a mastery of the elements of a whole group of basis sciences and of the formulated and transmitted experience of his own guild besides. But what common knowledge could social workers assume in like case? This was my query of fifteen years ago. It seemed to me then, and it is still my opinion, that the elements of social diagnosis, if formulated, should constitute a part of the ground which all social case workers could occupy in common, and that it should become possible in time to take for granted, in every social practitioner, a knowledge and mastery of those elements, and of the modifications in them which each decade of practice would surely bring."

Miss Richmond disclaims the idea that book knowledge is sufficient to make an efficient social worker; yet, she insists, ordered knowledge must supplement inspiration.

The material for the book has evidently been drawn from a rich experience; the treatment is open-minded and undogmatic.

Basic Quantity Food Tables to Be Used in Determining the Daily Issue of Food to the Kitchen. Prepared for the use of institutions by the Department of Public Charities, City of New York, July, 1917. John A. Kingsbury, Commissioner; Henry C. Wright, First Deputy Commissioner; Louis J. McNally, Departmental Steward. Pp. 120. Cloth. Price, $1.25 postpaid. For distribution by the Municipal Reference Library, 512 Municipal Building.

All large public institutions have long felt the need of a better and more definite control of their food issue and consumption. This need has evidently impressed itself upon the Department of Public Charities of New York City, and the department has met the issue by compiling and publishing a book of tables, which sets forth the exact amount of issues of all foods to be used for any given number of persons. The book has a separate table for each of the following classes: officers and staff; nurses; other employees; hospital patients and inmates of homes for the aged; tuberculosis patients; feeble-minded inmates and patients; children in hospitals; lodgers at municipal lodging house; industrial workers at municipal lodging house.

These tables will save an enormous amount of calculation daily that has heretofore been necessary in figuring the total amount of each article of food to be distributed to the patients. With these tables in hand, all that the dietitian or steward need do is to turn to the page and column headed by the nearest number approximating the actual number to be fed, and there will be found the number of ounces or pounds of the article or articles to be distributed. The total amount to be distributed, of course, is based upon a definite per capita which is set forth in the table. These per capitas are the combined experience of the Department of Public Charities and the other departments in New York City operating public institutions, and inasmuch as they have proved of practical service during years of operation, they should be a distinct guide to any public institution.

These tables, if adopted generally by public institutions, might readily be incidental in the saving of vast quantities of food. Not only would such an accurate basis enable the superintendent to control the maximum amount distributed, but it would also assure the superintendent that a sufficient and proper amount were furnished to his patients or inmates. These tables, when combined with the food waste system, which is also in operation in the Department of Public Charities, give information of greatest value to a central department or to a superintendent of an institution. The one in control can be assured that a proper distribution of food is taking place, and he has in hand a basis with which he can check up issues at any time.

These tables are the outcome of an inquiry into public institutions throughout the country which was made by Henry C. Wright in 1910 and 1911 and published under the title of "Fiscal Control of State Institutions." Mr. Wright has, subsequent to that time, become first deputy commissioner of public charities, New York City, and the shortcomings which he found in the handling of the food problem throughout the country he has attempted to overcome in his administration of these matters in the institutions of New York City. Thus the tables, in a sense, are the outcome of nearly ten years of work with public institutions on the part of Mr. Wright.

English-Italian Phrase Book for Social Workers. A Phrase Book for the Use of Social Workers, Teachers, Physicians, and Nurses. By Edith Waller. Pp. 178. Paper, price 75 cents. Edith Waller, Morristown, N. J., 1916.

English-Italian Phrase book for Social Workers—Physicians' Supplement. By Edith Waller. Pp. 19. Paper, price 25 cents. Edith Waller, Morristown, N. J., 1916.

This book and its Physicians' Supplement are intended for the use of social workers and others who have some acquaintance with the Italian language. The phrases and the vocabulary have been well chosen. It would have been better, however, if the English and Italian versions had corresponded in the position of sentences, which is not always the case.

Books Received for Review

Medical and Surgical Reports of the Episcopal Hospital, Philadelphia. Vol. IV; 106 illustrations. Philadelphia, 1916.

Society and Prisons. Some Suggestions for a new Penology. By Thomas Mott Osborne, L. H. D. Pp. 246. Cloth. Price, $1.35 net. Yale University Press, New Haven, Conn., 1916.

The Castle of Cheer. By Charles Henry Lerrigo, author of "Doc Williams," etc. Pp. 304, with 2 illustrations. Cloth, price $1.25 net. Fleming H. Revell Company, New York, Chicago, Toronto, London, Edinburgh, 1916.

The Aftermath of Battle. With the Red Cross in France. By Edward D. Toland, with a preface by Owen Wister. Pp. 175, with illustrations. Cloth, price $1.00. The MacMillan Company, New York, 1916.

NEW INSTRUMENTS AND EQUIPMENT

VINCENZ MUELLER, Technical Editor.
GEO. W. WALLERICH, Associate Editor.

Please address items of news and inquiries regarding New Instruments and Appliances to the editor of this department, 327 Southeast avenue, Oak Park, Illinois.

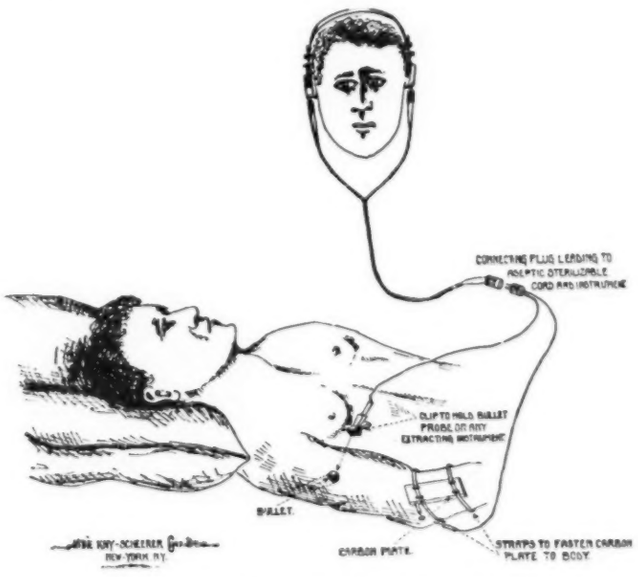
Electric Bullet Detector

This apparatus was developed under the direction of Dr. Mackenzie-Davidson of the British Medical Corps.

The instrument relies on a carbon plate being placed in contact with the human body as a positive element.

The materials used in the manufacture of bullets, shells, etc., are electronegative, and any particles within the human body form the negative element, therefore it will be found that the body itself forms the electrolyte. By completing the circuit between the two poles, a current is produced sufficiently strong to operate the detector.

After adjusting the headband and the receivers to the ear, a distinct sound is audible when a fragment of shell



Mackenzie-Davidson electric bullet detector.

or other metallic body is touched by the instrument which the operator has connected to the clamp supplied for the purpose.

The advantages claimed for this detector are: that it has no battery of any kind; that it is simple in construction, and that it will absolutely distinguish between metallic fragments and pieces of fractured bone. The device can be operated in conjunction with any bullet probe, forceps, or other surgical instruments, the use of which would be required under the circumstances.

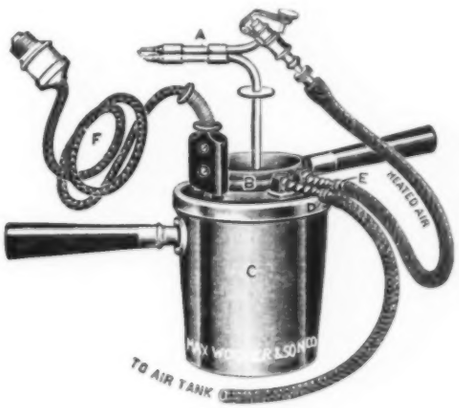
The portions coming in contact with the wound can be readily cleaned and sterilized.

Electrically Heated Paraffine Atomizer

This apparatus has been designed for the purpose of spraying Ambrine, Redintol, Parresine, Stanolind Surgical Wax, and other compounds used for dressing burns and granulated wounds.

The device consists of a copper, nickel-plated water container in which is also placed the electric heating unit for heating the water and the copper coil for the passage of compressed air. A removable container for holding the compound to be heated is placed into the outer vessel.

Where the electric current is not available, hot water may be used to melt the paraffine or other compound, and, even when electricity is used for heating, it is advisable to fill the container first with hot water rather than with cold water, for the reason that the higher temperature de-



Paraffine atomizer, electrically heated.

veloped by the heating unit will be available in a much shorter space of time.

The electric heating unit is set at 180 Fahrenheit, but it is estimated that the compressed air will reduce the temperature at the point of the spray from 20 to 30 degrees, and the degree of heat should be ascertained before the spray is used, and if it is too hot, the electric unit can be shut off.

With the use of heated compressed air such as this apparatus produces, the compound does not cool so quickly in the process of spraying and does not clog the tubes. The atomizer is held loose in the solution, and when spraying is completed it should be immediately withdrawn and air blown through the tubes in order to have the apparatus ready for future use.

Milk and Buttermilk Cooler

At this time of the year, we believe, there may be some of our readers who feel the need of some apparatus which will enable them to keep and dispense their milk and buttermilk in the most approved and sanitary fashion.

The "C. & H." milk and buttermilk cooler illustrated here is an apparatus which can be recommended for this purpose. The indurated fiberware container is a non-conductor of heat or cold, and consequently keeps the contents at the proper temperature at a minimum consumption of ice. The ice never comes in contact with the beverage, which is drawn through a non-clogging, non-corrosive faucet, thus making the cooler absolutely sanitary. A sanitary wooden dash (made of hard maple) prevents the lumps in the buttermilk from staying in one place. All of the liquid can be drawn from the cooler without disassembling it, making it easy to clean.

The cooler can easily be kept clean with warm water, a cloth, and a special brush furnished with it to clean the faucet.

The earthenware interior jar is made of the same kind of earthenware as used in the old-fashioned churn.

Cordley & Hayes milk and buttermilk cooler.

The coolers are furnished in four sizes with a capacity of the interior reservoir of approximately 1, 2, 2½, and 5 gallons. The outside of the apparatus is finished in white enamel.

Nephelometry

One of the most useful and widely spreading methods of chemical analysis recently developed is called nephelometry. The latest word in the construction of the nephelometers, the instrument used in the method, is brought out in a recent article by Kober (*Journal of Biological Chemistry*, 1917, XXIX, 155), the essential details of which are shown in the illustrations. The instrument is produced in this country.

Fig. 1. Showing details of the Kober colorimeter.

This new system of analysis, which shortens the time required for many determinations, does not demand an extensive knowledge of chemical technic. Results obtainable only after days in a laboratory can now be secured in a few minutes. Thus, the method is of value to clinicians who wish to obtain accurate results quickly for use in diagnosis and to those who have a deep interest in the causes of health and disease and who have little time for research.

Already the development of new and improved technic of many analysis has awakened among medical men a widespread interest in chemistry. But it is the duty of the pathologist so to shorten and simplify the process of analysis that it is possible for many clinicians to gather data which will throw light on the normal and abnormal conditions of the body for immediate or future use.

The chief basis of quantitative work is at present gravimetric analysis—filtering, washing, and weighing of precipitates. In all branches of chemistry and in physiological work particularly, this is a long, tedious process and often inaccurate, owing to the colloidal nature of the precipitates, and is largely responsible for the time consumed in analyzing.

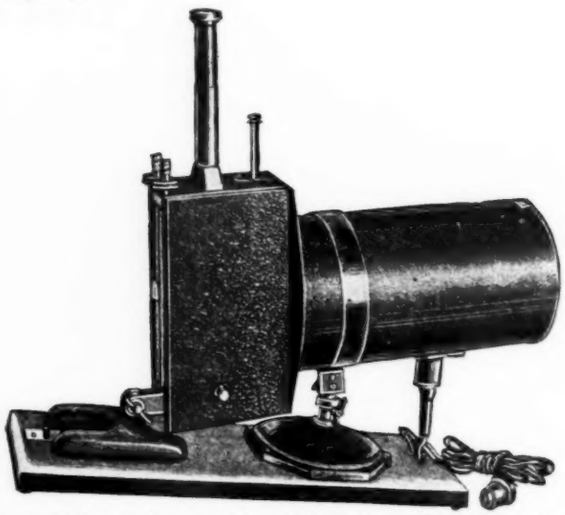


Fig. 2. Kober colorimeter with nephelometric and colorimetric lamp.

The place of volumetric analysis is already well known in acidity titration and in the estimation of chlorides and phosphates in urine, for example: Recently colorimetric analysis has been developed. Colors are produced and are estimated much as in oxyhemoglobin estimation by comparison with a known standard. Thus Folin has reduced to a clinical form the estimation of total nitrogen, urea, ammonia, uric acid, creatine, and creatinine, through such colorimetric reactions.

It is now proposed to add a photometric method of analysis called "nephelometry." The basis of the method is the measurement of the brightness of light reflected by a cloud—in other words, by the particles in suspension—very much like in an ultramicroscope. The intensity of the light reflected is a function of the quantity of suspended particles when other conditions are constant.

Dr. John C. Carmer, of Lyons, N. Y., opened a new hospital at that place September 1. The institution is to be called the "Edward J. Barber Hospital," being named for Edward J. Barber, vice-president of the Barber Steamship Company, of New York city, and a personal friend of Dr. Carmer. The hospital is open to all reputable physicians. Miss Elizabeth Hennesey, formerly assistant superintendent of a hospital at Brattleboro, Vt., is in charge.

A new home for the Huntington County Hospital, Huntington, Ind., was opened September 3. The building cost $52,000.

STANDARDIZATION OF HOSPITALS

Joint Session of the International and State Committees on Standards of the American College of Surgeons, Chicago, October 19-20, 1917

Last month announcement was made of a great meeting of physicians and hospital people in Chicago to confer on standardization of hospitals, under the auspices of the Clinical Congress of Surgeons of North America and the American College of Surgeons. The program had not been completed at the time our last number went to press. It has been completed now and follows:

I. HOSPITALS AS THEY ARE

1. The Problem of Standardization—Dr. Franklin H. Martin, Chicago.
2. Types of Hospitals, Numbers, Distribution, Ratio of Beds to Population, etc. (large maps, charts, etc.)—Dr. J. A. Hornsby, Chicago.
3. Relation of the Hospital to Its Community—President Henry A. Suzzallo, University of Washington, Seattle.

II. WHAT THE PROFESSION OF MEDICINE WANTS IN HOSPITALS

October 19, 2:00 p. m.

1. Organization and Efficiency—Dr. Christian R. Holmes, Cincinnati.
2. The Laboratory—Dr. William H. Welch, Baltimore.
3. Case Records and Their Value—Dr. Ernest A. Codman, Boston.
4. The Educational Responsibility of the Hospital to the Profession and to the Community—Dr. Allen B. Kanavel, Chicago.
5. The Trained Nurse—Dr. Anna Goodrich, New York.

III. WHAT TO DO—FIRST STEPS

October 19, 8:00 p. m.

1. Exact Data Essential as a Basis for Standardization of Hospitals—(a) Discussion opened by John G. Bowman, Chicago; (b) On Behalf of the American Hospital Association—Dr. W. L. Babcock, Detroit; (c) On Behalf of the Catholic Hospital Association—Father C. B. Moulinier, S. J., Milwaukee; (d) On Behalf of Research in Medicine and Surgery—Dr. Charles B. Mayo, Rochester, Minn.; (e) On Behalf of Medical Schools—Speaker not selected.

IV. WHAT TO DO AND HOW TO DO IT

October 20, 10:00 a. m.

1. State Committee on Standards and Their Work in Connection with Medical Societies, Hospital Governing Boards, and Hospital Superintendents—Dr. William D. Haggard, Nashville.
2. Closing Summary—Dr. George W. Crile, Cleveland.

V. AROUND THE TABLE

Dinner to Committeemenand Guests, 7:30 Saturday evening, October 20. Program not announced in advance.

It is intended by Dr. Franklin H. Martin, general secretary of the Clinical Congress, and by Dr. John H. Bowman, director of the American College of Surgeons, to invite about 300 leading surgeons and physicians of the country who are recognized in connection with their hospital work, and it is already assured that nearly all these men will be present, especially since the Clinical Congress takes place two days later, also in Chicago.

There have been invited also a number of the leading hospital men of the country, who have been asked to participate in the conference.

The chief purpose of the meeting is to arrive at some methods by which the problem of standardization of hospitals may be approached, and those who have already given serious consideration to the matter are under the impression that it will be wise to divide the country into definite districts and subdistricts. Each state of the Union will be a working district. There is to be a committee of three or five members of the medical profession and hospital leaders, who will act as the executive committee for the state. Under this committee each county is to be organized with a subcommittee for the county.

Approximately $40,000 has been appropriated by the American College of Surgeons for beginning the work.

As will be noted in the program, the conference to be held October 19 and 20 is divided into three essential parts: (1) the hospitals as they are; (2) what the hospitals need; and (3) how is the result to be brought about? This promises to be an epochal conference and one of vital interest to all the hospitals.

ARTIFICIAL DAYLIGHT IN SURGERY

Nearest Approach to Daylight Desirable Where Color Discrimination Is Required—A Study in Color Development

BY M. LUCKIESCH, Applied Science Department of The National Lamp Works, Cleveland.

Visual discrimination depends upon differences in brightness and in color; therefore the perception of color is important in most visual activities. However, except in viewing highly colored objects, such as rugs and paintings, we are usually unconscious of the part which color differences play in ordinary vision. This unconscious utilization of the gift of color vision becomes exceedingly evident through a general study of lighting and vision.[1]

It is a fundamental fact of the science of color that, in general, no colored object will appear the same under two different illuminants. In the case of a variegated colored object, the brightness relations of the different colors are altered as well as the hues. It is not unusual to experience helplessness in forming judgments in examining colored objects under ordinary artificial light, because, for several reasons, we have accepted the appearances of colors under natural daylight as standard. It appears needless to discuss the reasons why natural daylight possesses the most generally desirable quality or spectral character for purposes of color discrimination because everyone may draw upon his own experiences for such evidence. However, natural daylight has some disadvantages, for it is not constant in quality and intensity, and it is often unavailable when desired. These facts and others have been responsible for a growing demand for an artificial illuminant which approximates natural daylight in spectral composition—an artificial daylight.

Owing the variability of the spectral composition of daylight, it was necessary to determine average conditions before attempting to reproduce the spectrum of natural daylight by artificial means. The light from clear north sky is quite constant in spectral composition and fairly constant in intensity throughout a large portion of the day. Largely for these reasons, north skylight has been quite popular for accurate color work. Clear noon sunlight is also a fairly constant illuminant, which is more generally considered by physicists to be white in color. In comparison with noon sunlight, north skylight is decidedly bluish in hue. If we could integrate the color of total daylight from sunrise to sunset, we would arrive at a mean color perhaps quite different from either clear noon sunlight or north skylight.

For the preceding reasons and others, the development of artificial daylight units has not been confined to the reproduction of a single daylight quality, but has included several qualities of daylight. Artificial north skylight units are available for the most accurate color work. The essential parts of these accessories are a metal housing, a Trutint glass filter, and a light source. Owing to their steadiness, high efficiency, and convenience, Mazda C lamps are generally used in these so-called color-matching units. These units have been developed for the purpose of meeting the requirements of the most exacting color work, but

[1]Luckiesch, M.: Light and Shade and Their Applications; Color and Its Applications. Van Nostrand Company.

this highly accurate color discrimination is confined to a small portion of the entire field, and, therefore, for a vast range of activities in which color perception is utilized consciously or unconsciously, a less accurate approximation to daylight quality is necessary. Furthermore, outside this relatively smaller field of accurate color discrimination, the eyes are not so highly trained; therefore so-called Trutint sunlight units and also Mazda C-2 lamps serve the needs very well. These units are also more efficient than the color-matching units, and may be used for the general lighting of large areas.

At the present time thousands of Trutint units and several hundred thousand Mazda C-2 lamps are in operation in commercial and industrial activities. Many of these are in use in surgery and medicine for the general illumination of operating rooms and for purposes of medical examination. They combine the advantages of daylight quality of light and reliability. As previously stated, the perception of color enters into the process of visual discrimination to a surprising extent. For example, the manifestations of skin diseases are judged to a large extent by color, and a judgment of such a condition is arrived at more or less falteringly under ordinary artificial light. Flesh tints vary in color, and healthy and diseased tissues are discriminated largely through differences in color. The color of flesh tissue is usually quite different under ordinary artificial light than under daylight, and usually there are not such apparent differences between the various flesh tints under the former illuminant as under the latter. In microscopy the same conditions arise with the additional difficulties arising from the uncertainties in recognizing stains under ordinary artificial light.

It appears unnecessary to describe the present installations in detail, because medical men doubtless fully appreciate the advantages of such illuminants. In most cases the Mazda C-2 lamp appears to be satisfactory, and it possesses the advantage of being easily installed. However, for localized lighting, the Trutint color-matching unit is in use in a number of cases for the purpose of diagnosis. In dentistry, microscopy, and other laboratory work, these various units also have found application.

COUNTRY HOSPITALS FOR CANADA

Crying Need for Medical Skill and Nursing Care in Sparsely Settled Districts—Government-Supported Hospitals Only Solution

A committee appointed by the National (Canadian) Council of Women to investigate the need of skilled maternity care for the young mothers in the sparsely settled districts has rendered a report, which is published in a recent number of the *Canadian Nurse*. The committee finds the need for more medical skill and nursing care in the remote and thinly settled portions of Canada to be very great. Thousands of women have no other care than that furnished by their husbands or by kindly neighbors; sometimes they have passed successfully through childbirth without even this aid. In many cases, however, physical defects and the hard life of the women on the homesteads produce conditions which endanger the life and health of mother or child, or both. Moreover, it is often impossible for the mothers to stay in bed the requisite number of days.

The need is so vast that the Victorian Order of Nurses barely touches its fringe, although a number of country branches have been opened during the past two years, and some new hospitals established from which nurses are sent out. The extension of the Victorian Order would do much to relieve the situation, but could not completely meet the demand, because the need for more experienced medical skill is as great as that for nursing care. Not maternity only, but accidents, organic diseases, fever, etc., need to be provided for, and this irrespective of the financial condition of the patients. The only solution, in the committee's opinion, is the provision by the dominion and provincial governments of a system of small hospitals. The committee says:

"The solution of the whole problem, in the opinion of your committee, is the provision of small country hospitals, with qualified and competent nurses in charge and medical skill available, the hospital to furnish both nursing accommodation to all patients who can come in, and a home for a staff of visiting nurses who go out to those patients who from various causes are unable to leave their homes.

"This is a large scheme and could only be undertaken successfully by the governments.

"The dominion and provincial governments spend much time and money in conservation of animal and forest life, and in assisting agriculture, mining, and other industries. They have hitherto overlooked to a great extent the preservation of human life, which is, without doubt, the most important of all.

"If a man has a sick beast he can claim the services of a veterinary at the expense of the government, but a sick member of his family is without any such claim.

"The government, dominion and provincial, should be asked to provide medical and nursing care not only for the mothers, but also for the fathers, sons, and daughters, in the outlying districts.

"In Manitoba the provincial government has appointed six nurses for welfare work in the outlying districts. Their work is purely educational, and their object the conservation of child life.

"They are also expected to educate the public along such lines as hygiene, prevention of contagious diseases, etc. They will accomplish much work if they can teach the husbands and fathers that child-birth, though a natural function, does need care and sufficient rest to make a good recovery. Many women complain that they cannot rest after the baby is born on account of the household tasks. The fathers at such times should do the necessary work and make the bread.

"The life of the wife and child of a large number of these settlers is not as valuable in their eyes as it should be. There is need of education along these lines.

"In Alberta a free public hospital league has been organized, and it is the intention of the league to petition the government of Alberta to establish free public hospitals.

"The idea is to form a chain of small hospitals, the cost to be borne by a tax of one cent an acre on all lands, the hospitals to be free as schools are free, kept up as schools are, and placed as schools are placed, wherever there is need, and not more than twenty or forty miles apart.

"In closing this report your committee would like to state they are convinced that any scheme undertaken to help the sick in the sparsely settled districts, to be successful, must have the authority of the government as well as its financial aid."

A new home for the nurses of the Thomas D. Dee Memorial Hospital at Ogden, Utah, was dedicated the last week in August. The building, with its furnishings, cost $35,000, and has accommodations for 50 nurses.

The MODERN HOSPITAL

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NEWS OF THE HOSPITAL FIELD

Eastern States

Dr. W. E. Putnam is opening a private hospital at Bennington, Vt.

Hamot Hospital, Erie, Pa., launched in September a campaign to raise $325,000.

St. Margaret's Hospital, Pittsburgh, Pa., will launch a campaign in October to raise $200,000 for maintenance and to erect a home for its nurses.

The Carlisle Hospital, Carlisle, Pa., has recently purchased ground for a nurses' home. New quarters for the hospital were opened a year ago.

Miss Martha Kauffman, superintendent of the Polyclinic Hospital, York, Pa., underwent an operation at that hospital in September for appendicitis.

Every county in the state of New York not already maintaining a tuberculosis sanatorium is required by law to establish such an institution by July, 1918.

The Huntington General Hospital, Huntington, W. Va., has announced plans for remodeling its quarters and erecting an addition to house its surgical department.

St. Christopher's Hospital for Babies, Brooklyn, N. Y., which moved into new quarters early this year, has just recently opened a free clinic for children under twelve years.

Mr. E. J. Edsall has resigned the superintendency of the St. Margaret Memorial Hospital, Pittsburgh, Pa., after an incumbency of several years. He will leave the institution October 1.

Ground was broken September 14 for a home for the nurses of the new Greenwich Hospital, Greenwich, Conn. A building costing, with furnishings, approximately $45,000, will be erected.

The Lehigh Valley Coal Company has lately opened at Centralia, Pa., a hospital for its employees. Dr. Frank Marshall, of Ashland, Pa., is in charge of the hospital, with Miss Mary Campbell as head nurse.

Mr. C. A. Lindblad, superintendent of the Pittsburgh Homeopathic Hospital, Pittsburgh, Pa., is taking military training at Fort Oglethorpe, Ga., having been granted a three-months' leave of absence by the hospital authorities.

A fifth floor has recently been added to the Flushing Hospital, Flushing, N. Y., formerly a four-story building. The addition is a gift from Mrs. Angie M. Booth, widow of the late Henry Prosper Booth. It provides, among other facilities, a new operating suite.

A state hospital for miners will probably be erected at Shenandoah, Pa., in the near future. Such an institution is said to be urgently needed to relieve the State Hospital for Injured Persons at Fountain Springs, the capacity of the latter institution being overtaxed.

Architects have been engaged by the Chester Hospital, Chester, Pa., to draw plans for a new operating room and work out a comprehensive scheme for the general expansion of the hospital plant as the future demands upon the institution may necessitate greater facilities.

Dr. David St. John, long a prominent physician of Hackensack, N. J., and one of the organizers of the Hackensack Hospital, died at his country home at Berne, N. Y., on September 14, after an illness of more than a year. At the time of his death Dr. St. John was a member of the

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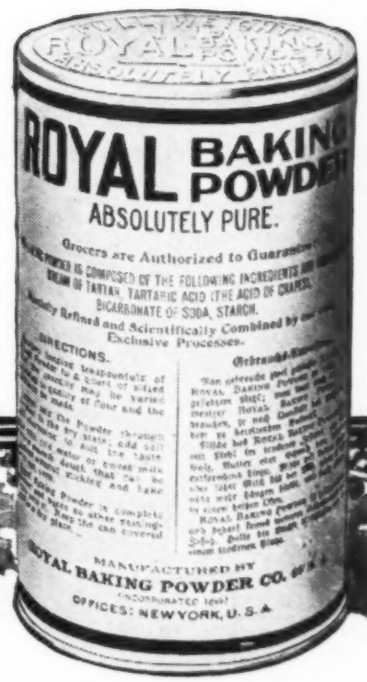

board of managers of the New Jersey State Hospital for Insane, at Morris Plains. His son, Dr. Fordyce St. John, is in France as a member of the staff of the Presbyterian Hospital of New York.

Miss Blanche M. Truesdell, formerly superintendent of the Wichita Hospital, Wichita, Kan., has accepted an appointment as superintendent of the Ossining (N. Y.) Hospital, where she succeeds Miss Josephine Swenson, who resigned to go to France as a Red Cross nurse.

Increasing demands upon the Volunteer Hospital, 117 Beekman St., New York city, has made it necessary for the institution to proceed with the erection of a four-story addition, which was planned some time ago, but postponed on account of the prevailing high prices of building material.

The hospital committee of the International and Great Northern Railway employees, recently visited several towns along the line of the road in Texas, looking for a location for a $100,000 hospital to be erected in the near future. The selection of a site has not yet been announced.

In celebration of her birthday anniversary, Miss Mary A. Smith, superintendent of the York Hospital and Dispensary, York, Pa., on the evening of September 17, was tendered a banquet by the nurses and other employees of the institution and presented with a gold wrist watch as a token of esteem.

Miss E. Leta Card, former superintendent of nurses at the Polyclinic Hospital Post-Graduate School for Nurses, New York city, was married at her home in Port Hope, Ontario, on September 3, to Hon. Lewis Emery, Jr., of Bradford, Pa. Mr. and Mrs. Emery will spend the winter in the British West Indies.

Dr. A. L. Kotz, formerly pathologist at St. Luke's Hospital, South Bethlehem, Pa., has recently accepted a position of the same kind at the Easton Hospital, Easton, Pa. The laboratory of the latter institution will be enlarged to provide greater facilities for pathological work than it has heretofore afforded.

The Allentown Hospital, Allentown, Pa., has just issued a report showing that its per capita cost of maintenance has increased 20 percent in the last year. The increase is attributed to the higher prices of foods, medicines, and labor. One hundred and sixty-six patients per day, on an average, were cared for at this institution during the month of August at a daily cost of $1.97 per patient.

According to an announcement recently made by Major-General Gorgas, surgeon-general of the army, sites for reconstruction hospitals in which the government will begin the work of rehabilitating crippled soldiers for private life, have been chosen tentatively in nineteen cities, as follows: Boston, New York, Philadelphia, Baltimore, Washington, Buffalo, Cincinnati, Chicago, St. Paul, Seattle, San Francisco, Los Angeles, Denver, Kansas City, St. Louis, Memphis, Richmond, Atlanta, and New Orleans. The hospitals at Boston, New York, Washington, and Chicago probably will be the first built. Each of these will be equipped to care for 500 patients, with provision for doubling this capacity if necessary.

Southern States

Dr. J. M. Alexander and others, of Abilene, Tex., are planning to build a $30,000 hospital.

The Florida Hospital for the Insane at Chattahoochee has a new superintendent—Dr. H. Mason Smith—formerly a member of the medical staff.

The tuberculosis sanatorium which the state of Mississippi is establishing at Magee will soon be ready for patients. Dr. H. Boswell has been appointed superintendent.

Work has been started on the foundation for a $225,000 addition to the Baptist Memorial Hospital at Memphis, Tenn. The building will be eight stories high, including basement, and will be arranged to accommodate 150 patients.

Announcement has been made by the War Relief Commission of the Benevolent and Protective Order of Elks, that the first base hospital, which will be established out of the fund of $1,000,000 raised by this order for war re-

lief, will be in charge of surgeons and nurses from the University of Virginia, at Charlottesville. The hospital will cost $60,000.

The city commission of Knoxville, Tenn., is considering a plan to purchase the Lincoln Memorial Hospital, of that city, and operate it as a branch of the Knoxville General Hospital.

Dr. Sam P. Oldham, of Owensboro, Ky., has recently purchased in that city a large modern residence, which he announces will be converted into a private hospital, the first institution of the kind to be established in Owensboro.

Dr. Leighton Leak, of Syracuse, N. Y., has lately been elected superintendent of the South Carolina State Hospital for Insane at Columbia. Dr. Leak has been in charge of the psychopathic branch of the Syracuse City Hospital for several years.

Middle Western States

The City Hospital, Salem, O., has recently opened a new home for its nurses.

A movement is on foot at Ravenna, O., to reopen the White Hospital of that city.

Parkview Hospital, Jamestown, N. Dak., has lately been transferred to the Sisters of St. Joseph.

A campaign to raise $25,000 for improvements is being conducted by Mercy Hospital, Manistee, Mich.

Dubuque County, Iowa, is offering for sale a bond issue of $75,000 for the erection of a county hospital.

Dr. Maulton, Bellevue, Ia., is having plans drawn for a private hospital which he expects to erect at that place.

Miss Emma Frieby has resigned the superintendency of the city hospital at Grand Rapids to accept a position in California.

St. Vincent's Charity Hospital, Cleveland, O., graduated 14 nurses at its 16th training school commencement, held September 18.

St. Joseph's Hospital, South Bend, Ind., has had plans drawn for a three-story addition, which it expects to erect next year at a cost of $70,000.

A community hospital is under construction at Newton, Ia., and will be ready for patients some time in October. It will have a capacity of 15 beds.

The Methodist Hospital, Indianapolis, has recently acquired the Princeton Sanatorium at Princeton, Ind., and will operate it as a branch hospital.

Contract has been awarded by the Northwestern Hospital at Minneapolis for the erection of a service building to cost, complete, approximately $100,000.

The Christian Orphans' Home at St. Louis announces the opening of a new hospital building, which will be devoted to the care of inmates of the home.

Damage to the extent of $20,000 resulted when the dairy barns at the Rochester State Hospital, Rochester, Minn., were recently struck by lightning and destroyed.

Dr. E. O. Milley, who has been conducting the Romeo Sanitarium at Romeo, Mich., has sold his interest in the institution to Dr. Boorheis, of Lansing, Mich., who is now in charge.

Dr. J. S. Kellogg, head of the Battle Creek Sanitarium, Battle Creek, Mich., suffered severe bruises recently when an automobile in which he was riding was driven into a tree and wrecked.

The commissioners of Anderson County, Ind., will receive bids in October on the erection at Ft. Wayne of a tuberculosis hospital, for which an appropriation of $100,000 has been made.

The Milwaukee County (Wis.) Committee on County and State Institutions has recommended to the county supervisors that $90,000 be expended in the erection of a children's hospital in connection with Muirdale, the county's tuberculosis sanatorium at Wauwatosa.

Dr. H. J. Gahagan, for the last four years superintendent of the Elgin State Hospital, Elgin, Ill., was succeeded

September 6 by Dr. Ralph Hinton. Dr. Gahagan will resume private practice in Chicago.

Dr. Elliott Washburn, lately superintendent of the state tuberculosis hospital at Rutland, Mass., became general manager of the hospital department of the Kansas City (Mo.) board of health September 3.

The Children's Hospital, Columbus, O., purchased in September, a site for a complete new hospital, which it plans to erect in the near future. Money to defray the cost of the building was raised last year.

The Defiance City Hospital, Defiance, O., was formally opened late in August, with Miss House as superintendent and Miss Sands, a graduate of Wesley Memorial Hospital, Chicago, in charge of the surgical department.

The Hancock Public Hospital is a new institution at Hancock, Mich. The building is a remodeled residence with accommodations for 40 patients. Miss Holomba, a Chicago nurse, has been appointed superintendent.

Miss Stella M. Freidinger, superintendent of the John C. Proctor Hospital, Peoria, Ill., has been granted leave of absence to take a course in hospital administration at the Teachers' College of Columbia University, New York City.

The Plymouth Hospital, a new Lutheran institution at Plymouth, Wis., will be opened October 1. The building is a two-story and basement structure, representing an investment of $35,000. Thirty patients can be accommodated.

Articles of incorporation have been filed by the Muncie Home Hospital Company, Muncie, Ind., which has been organized to take over the Home Hospital, a private institution at Muncie, and operate it for the benefit of the community.

Kenosha, Wis., is soon to have a new Catholic hospital. The institution will be established by the Dominican Sisters, who conduct the Holy Rosary Hospital at Ontario, Ore. Arrangements looking toward the erection of the building are already being made.

A movement is under way for the joint establishment by Huron, Sandusky, Erie, Lorain, and Ottawa counties, Ohio, of a tuberculosis sanatorium to cost $200,000. The plan contemplates provision for the care of soldiers who may contract tuberculosis in the war.

The cornerstone of a new hospital at Bluffton, Ind., was laid September 3. Thirty thousand dollars toward the establishment of the institution has been appropriated by the county and the balance will be raised by popular subscription. It will be known as the Wells County Hospital.

Rev. Reinhold Niebuhr, pastor of Bethel Evangelical Church, Detroit, Mich., writes THE MODERN HOSPITAL that an Evangelical Deaconess Hospital will soon be opened in Detroit. Besides Mr. Niebuhr, Sister Melinda Schmidt, a member of the deaconess order, is active in the work of launching the new institution.

A hospital and colony for epileptics was opened by the state of Iowa September 3. The institution, which consists of a group of one- and two-story modern cottages, erected at a cost of over half a million dollars, is located on a 1,000-acre tract of land, near the town of Woodward, about 25 miles north of Des Moines.

Dr. John W. Sluss, of Indianapolis, a former superintendent of the Indianapolis City Hospital and now a major in the Army Medical Corps, has been assigned to the post of chief of the surgical division of the base hospital at Camp Grant, Rockford, Ill. Dr. Sluss has been connected with the medical branch of the Indiana National Guard for many years.

Monticello, Ia., on September 5, celebrated the completion of a community hospital, erected as a memorial to a former citizen, the late John McDonald, who left $150,000 to establish and endow the institution. The building is a modern, fireproof structure, three stories high, with 30 beds for adult patients and a separate ward for children. It cost about $60,000.

The University of Iowa, Iowa City, has selected a site for its proposed Children's Hospital, for the establishment of which the last Iowa legislature appropriated $150,000.

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The tract of land decided upon comprises 33 acres and adjoins the present grounds of the institution. More than 100 children are now under treatment at the general hospital maintained by the university.

Dr. A. Howard Smith, founder and owner of the Smith Hospital at Marietta, O., has offered his services to the government, and has been accepted for duty with a hospital in France. During his absence Dr. Smith's hospital will be conducted by Dr. R. W. Athey and Dr. John McClure, both of Marietta. Mrs. Smith will accompany the doctor to France as a Red Cross nurse.

By the will of the late Mrs. Elizabeth Condell, of Libertyville, Ill., the residents of that town are to receive $20,000 with which to establish a community hospital, on the condition that $5,000 additional be raised by popular subscription. Dr. John L. Taylor, Judge Benjamin H. Miller, and Senator R. B. Swift are among those named to form a board of directors for the hospital.

Petitions are being circulated at Flint, Mich., and other places in Genesee County, asking the board of county supervisors to call an election on a $100,000 bond issue for the establishment of a county tuberculosis sanatorium, Dr. William De Kleine, city health officer of Flint, and former director of the Michigan tuberculosis survey, is acting in an advisory capacity in the movement.

St. Elizabeth's Hospital, Dayton, O., has a new superintendent, Sister Liguori, who has been transferred from St. Anthony's Hospital, Woodhaven, N. Y. Sister Liguori conducted the Woodhaven institution for a number of years, and prior to taking up her work there, was for a long time connected with St. Joseph's Hospital in New York City. She was born in Dayton and received her first hospital training there in the hospital, then newly founded, which, after more than 30 years, she has now returned to manage.

A recently incorporated company has taken over the management of the Orchard Springs Sanitarium at Dayton, O. Dr. J. C. George is succeeded as medical director by Dr. R. W. Adkins, who until recently was assistant superintendent of the Dayton State Hospital. Dr. A. F. Shepherd, former owner of the institution, retains connection as president of the board of directors and consulting psychiatrist. Improvements and additions to the sanitarium are being made.

A new home for the Grant County Hospital at Marion, Ind., was opened September 1. The building was erected at a cost of $70,000, and is equipped to accommodate 40 patients, with room for as many as 75 in case of emergency. Funds to provide the new structure were raised by popular subscription. Miss Augusta Olson, who was in charge of the institution in its old quarters, will continue as superintendent, with Miss Pearl Hayes as assistant superintendent.

The first unit of the hospital which the recently organized McKinley Hospital Company at Columbus, O., proposes to erect is to be a six-story and basement fireproof structure, costing $200,000, and containing accommodations for 112 private patients. Bids on the construction work were received in September. Additional units to be erected later are provided for in the plans, which have been drawn by architects Stribling & Lum, Columbus. Dr. F. F. Lawrence, of Columbus, is actively interested in the project and will have charge of the institution when it is put into operation.

The Sisters of the Sacred Heart, in Chicago, are having plans prepared for what promises to be one of the most elaborate sanatoriums in the United States. The sanatorium is to be erected at St. James' court and Lake View avenue, Chicago, and is estimated to cost about $800,000. It will consist of one large building, one section of which will be eleven stories high, and the other eight stories. The building will cover a plot of ground 190 by 156 feet. In the center will be an oval-shaped patio, 50 by 60 feet, extending the full height of the building, and surrounded by a dome of ornamental glass. The plans provide for two hydrotherapeutic departments on the ground floor for men and women, each with a swimming pool, steam and hot rooms, electric baths, massage, and douche rooms. The

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mezzanine and first floors will be given over to private hydrotherapeutic departments for guests. On the ground floor will be located the culinary department and dining room for employees, while on the main floor will be two ladies' parlors, reception, men's lounging, smoking, breakfast, dining, and service rooms. There will be 156 guest rooms in the building. An unusual feature will be a promenade on the ninth floor, leading out to a roof garden elaborately laid out with pergolas, tennis and squash courts. It is announced that the construction work will probably be started next spring.

Prominent business men of Indianapolis and other Indiana cities have become interested in a movement for the establishment in Indianapolis of a free hospital for invalid and deformed children of the state, as a memorial to the late James Whitcomb Riley. The plans for the hospital contemplate the operation of a bureau for the dissemination of knowledge on the care of children, also a training school for nurses. Although it is not proposed to begin the construction of the hospital until the close of the war, steps have already been taken toward the raising of a fund of $2,000,000 for buildings and endowment. A committee of seven, appointed to work out the details for the establishment of the institution, consists of Josiah K. Lilly, W. C. Bobbs, James A. Allison, L. C. Boyd, and Henry Kahn, all of Indianapolis; Will G. Irwin, of Columbus; and Frank C. Ball, of Muncie.

A conference of officials of the Wisconsin Anti-Tuberculosis Association and heads of eastern Wisconsin county sanatoriums was held at Appleton September 8. Talks were made by Dr. C. D. Boyd, of Kaukana, on "The Relation of the Trustee to the Sanatorium"; Miss Helen Scheller, of the Winnebago County Sanatorium, on "The Blanket Problem"; Miss Elizabeth Leehouts, chief nurse of the out-patient department of the Milwaukee County Sanatorium, on "Out-Patient Work in a Small Sanatorium"; and Miss Emma Conkley, of the Extension Division of the University of Wisconsin, on "Cooking and Serving Foods." Mr. Otto F. Bradley, of Milwaukee, who presided, declared that since the work of the state association along the line of segregation was started, there has been a gradual decrease in the number of cases of tuberculosis reported, and that at present the tuberculosis death rate is lower than the rate of deaths from pneumonia. Recent draft examinations have revealed many cases of tuberculosis not previously known to exist, Mr. Bradley said, and it is understood that one of the purposes of the meeting was to bring the sanatorium superintendents together for a discussion of the problem of caring for these new patients.

Rocky Mountain and Pacific Coast States

Construction work has been started at Colorado Springs, Colo., on a detention hospital for the city and county to cost $25,000.

Rev. Curtis Mogg has succeeded Dr. Walter Morritt as superintendent of the Beth-El Hospital at Colorado Springs, Colo.

Improvements, which will include a new wing, a home for nurses, and some new equipment are under way at the Wardner Hospital, Kellogg, Idaho.

The Medical Springs (Ore.) Hotel and Sanatorium, which was destroyed by fire in August, will be rebuilt, according to an announcement made by the owner, Dunham Wright.

Miss Nellie Davidson, formerly superintendent of the Pajaro Valley Hospital at Watsonville, Cal., has lately taken the position of head nurse at the Jim Bardin Hospital, Salinas, Cal.

Misses Lassen and Harcourt, who have had charge of the Redwood City Hospital, Redwood City, Cal., for the last two years, are giving up this work to do nursing at the battle front in France.

Physicians of Gooding, Idaho, are undertaking to organize a stock company to establish a hospital at that place. It is proposed to purchase a large residence and have it remodeled for hospital purposes.

Mrs. Edith T. Brand, R. N., who, for the last two years, has been connected with the Shannon Copper Company

Hospital at Clifton, Ariz., has lately accepted an appointment as superintendent of the Gila County Hospital at Globe, in the same state.

It is reported that a private sanatorium will soon be established near Clearwater, Mont., at the terminus of the new Milwaukee railway line. Dr. Frederick K. Lewis, of Ovanda, Mont., who is at the head of the undertaking, is said to have interested quite a number of prominent Chicago physicians.

The building for male patients at the Wyoming State Hospital at Evanston is a total wreck as the result of a fire which occurred at that institution the afternoon of September 14. The loss, which is estimated at $100,000, is largely covered by insurance. All of the 150 patients in the building were safely removed.

Dr. William Friedberger, for the last five years superintendent of the San Joaquin County Hospital, Stockton, Cal., has received a commission as first lieutenant in the medical officers reserve corps, and has been given leave of absence by the hospital board until the end of the war. While Dr. Friedberger is away the hospital will be in charge of Dr. Jesse W. Barnes, of Marysville, Cal.

A new home for the San Bernardino County Hospital, San Bernardino, Cal., erected at a cost of $100,000, will be opened in October. With the completion of this building the San Bernardino supervisors announce tentative approval of plans for a tuberculosis hospital to be erected and maintained jointly by San Bernardino and Riverside counties.

The voters of Alameda County, Cal., have approved a bond issue of $1,000,000 for the erection of a county hospital in Oakland. The present county hospital is operated in connection with the county infirmary at San Leandro, where the facilities are inadequate, and the voting of the $1,000,000 bond issue will serve the double purpose of providing suitable modern buildings and establishing the hospital nearer the center of the county's population.

Dr. R. J. Cary, for the last two years in charge of Mountain View, Pierce County's tuberculosis sanatorium, at Lakeview, near Tacoma, Wash., has accepted an appointment as superintendent of the new Alameda Sanatorium at Livermore, near Oakland, Cal. Dr. Cary is a graduate of the Johns-Hopkins medical school, and served as resident physician in the St. Francis and Tuberculosis League hospitals, Pittsburgh, Pa. The new appointment carries an advance in salary.

Dr. Elizabeth A. Follansbee, who, with Dr. Charlotte Blake Brown, organized the Hospital for Children and Training School for Nurses in San Francisco in 1877, and assumed the post of resident physician, died in the county hospital at Los Angeles August 22, after an illness lasting many months. Dr. Follansbee opened an office in Los Angeles in 1882 and is said to have been the first woman physician to practice in that city. For 25 years she was a member of the faculty of the University of Southern California. She was graduated from the Woman's Medical College, Philadelphia, in 1877, and had previously studied medicine in the state universities of California and Michigan. Dr. Follansbee was a native of Maine.

United States Territorial Possessions

A $50,000 hospital is being erected at Zamboanga, P. I., by the government. Two mission hospitals are already in operation at this place, but they are said to be inadequate to the demands for hospital service.

The Japanese Benevolent Society, of Honolulu, has launched a campaign to raise $40,000 for the completion of a fund for a new hospital building. It is expected that the most of this money will be contributed by resident Japanese, who have already subscribed more than $50,000, it being their purpose to erect an $80,000 building on a site which they estimate will cost in the neighborhood of $12,000. The society has maintained a hospital in Honolulu since the year 1900.